S. HRG. 99-126

REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

HEARING

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

ON

S. 277

TO REAUTHORIZE AND AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT, AND FOR OTHER PURPOSES

MARCH 6, 1985

WASHINGTON, DC

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REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

MARCH 6, 1985

U.S. SENATE,
SELECT COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 11:01 a.m., in room SD-106, Dirksen Senate Office Building, Senator Mark Andrews (chairman of the committee) presiding.

Present: Senators Andrews, Bingaman, Murkowski, Melcher, and Inouye.

Staff present: Peter S. Taylor, staff director; Pat Zell, staff attorney; Paul Alexander, staff attorney; and Max I. Richtman, minority staff director.

Senator ANDREWS. Good morning.

This morning we will hear testimony on S. 277, a bill to amend and reauthorize the Indian Health Care Improvement Act.

I would like to call Dr. Robert Graham who is the Administrator of the Health Resources and Services Administration of the Department of Health and Human Services from Rockville, MD. He is accompanied by Dr. Everett Rhoades who is the Director of the Indian Health Service, also in Rockville MD.

I see you are accompanied by a number of others. Welcome to the committee, again. It is good to see you. We enjoyed your testimony at the budget hearings, and now we welcome you back to testify on Indian health care.

Let me mention that this bill is a bill to amend and reauthorize the Indian Health Care Improvement Act of 1976. I am proud to say that 20 Senators joined me as cosponsors of this very important legislation when it was introduced in this Congress. Similar legislation was passed by both the Senate and the House of Representatives in the last Congress but was vetoed by the President.

S. 277 has been modified in a way that I am confident will meet the President's objections. Although he has not told me that, we hope it works out that way. In addition, a few new provisions have been added to address health promotion and disease prevention program needs, to provide for a juvenile alcohol and drug abuse program, and other matters.

At this point I will place a copy of S. 277 in the hearing record.

[The bill follows. Testimony begins on p. 77.]

99TH CONGRESS
1ST SESSION

S. 277

To reauthorize and amend the Indian Health Care Improvement Act, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 24 (legislative day, JANUARY 21), 1985

Mr. ANDREWS (for himself, Mr. ABDNOR, Mr. BAUCUS, Mr. BINGAMAN, Mr. BOSCHWITZ, Mr. BURDICK, Mr. COCHRAN, Mr. DECONCINI, Mr. DOMENICI, Mr. DURENBERGER, Mr. GOLDWATER, Mr. GORTON, Mr. INOUYE, Mr. KENNEDY, Mr. MELCHER, Mr. MURKOWSKI, Mr. PRESSLER, Mr. STEVENS and Mr. EVANS) introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

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A BILL

To reauthorize and amend the Indian Health Care Improvement Act, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "Indian Health Care Amendments of 1985".

REFERENCES

SEC. 2. Except as otherwise specifically provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Indian Health Care Improvement Act (25 U.S.C. 1601, et seq.).

TITLE I—INDIAN HEALTH MANPOWER

HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS

SEC. 101. Subsection (c) of section 102 (25 U.S.C. 1612(c)) is amended to read as follows:

"(c) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

"(1) $600,000 for fiscal year 1986,

"(2) $650,000 for fiscal year 1987,

"(3) $700,000 for fiscal year 1988, and

"(4) $750,000 for fiscal year 1989.".

HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM

SEC. 102. (a) Section 103 (25 U.S.C. 1613) is amended by striking out subsection (d) and inserting in lieu thereof the following:

"(d) The Secretary shall not deny scholarship assistance to an eligible applicant under this section solely on the basis of the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution.

"(e) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

"(1) $4,700,000 for fiscal year 1986,

"(2) $5,400,000 for fiscal year 1987,

"(3) $6,100,000 for fiscal year 1988, and

"(4) $6,800,000 for fiscal year 1989.".

(b) Subsection (c) of section 103 is amended by striking out "expenses" and inserting in lieu thereof "expenses of a grantee while attending school full time".

INDIAN HEALTH SERVICE EXTERN PROGRAMS

SEC. 103. Section 105 (25 U.S.C. 1614) is amended by striking out subsection (d) and inserting in lieu thereof the following:

"(d) No stipend may be paid to any person under section 103 or 104 while such person is employed under this section.

"(e) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

"(1) $350,000 for fiscal year 1986,

"(2) $400,000 for fiscal year 1987,

"(3) $450,000 for fiscal year 1988, and

"(4) $500,000 for fiscal year 1989.".

HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

SEC. 104. Title I is amended by adding at the end thereof the following new sections:

"INDIAN HEALTH PROFESSIONS SCHOLARSHIPS

"SEC. 107. (a) In order to provide health professionals to Indian communities, the Secretary, acting through the Service and in accordance with this section, shall make scholarship grants to Indians who are enrolled full time in schools of medicine, osteopathy, dentistry, veterinary medicine, nursing, optometry, clinical psychology, public health, and allied health professions. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with section 338A of the Public Health Service Act (42 U.S.C. 254l) except as provided in subsection (b) of this section.

"(b)(1) The Secretary, acting through the Service, shall determine who shall receive such scholarships and shall determine the distribution of such scholarships among such health professions on the basis of the relative needs of Indians for additional service in such health professions.

"(2) An individual shall be eligible for a scholarship under subsection (a) in any year in which such individual is enrolled full time in a health-profession school referred to in subsection (a).

"(3) The active duty service obligation prescribed under section 338B of the Public Health Service Act (42 U.S.C. 254m) shall be met by a recipient of an Indian Health Scholarship by service in the Indian Health Service, including service under a contract under the Indian Self-Determination and Education Assistance Act (Public Law 93-638); in a program assisted under title V of this Act; or in the private practice of his profession if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

"(c) For the purpose of this section, the term 'Indian' has the same meaning given that term by subsection (c) of section 4 of this Act, including all individuals described in clauses (1) through (4) of that subsection.

"(d) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

"(1) $7,000,000 for fiscal year 1986,

"(2) $8,100,000 for fiscal year 1987,

"(3) $9,234,000 for fiscal year 1988, and

"(4) $10,300,000 for fiscal year 1989.

"COMMUNITY HEALTH REPRESENTATIVE PROGRAM

"SEC. 108. (a) Under the authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary shall maintain a Community Health Representative Program under which the Service—

"(1) provides for the training of Indians as health paraprofessionals, and

"(2) uses such paraprofessionals in the provision of health care to Indian communities.

"(b) The Secretary, acting through the Community Health Representative Program of the Service, shall—

"(1) provide a high standard of paraprofessional training to Community Health Representatives to ensure that the Community Health Representatives provide quality health care to the Indian communities served by such Program, and

"(2) in order to provide such training, develop a curriculum that—

"(A) combines education in the theory of health care with supervised practical experience in the provision of health care,

"(B) provides instruction and practical experience in health promotion and disease prevention activities, particularly—

"(i) nutrition,

"(ii) physical fitness,

"(iii) weight control,

"(iv) cessation of tobacco smoking,

"(v) stress management,

"(vi) control of alcohol and drug abuse,

"(vii) control of high blood pressure, and

"(viii) prevention of lifestyle-related accidents, and

"(C) provides instruction in the latest and most effective social, educational, and behavioral approaches to the establishment and maintenance of good health habits,

"(3) develop a system which identifies the needs of Community Health Representatives for continuing education in health care, health promotion, and disease prevention and develop programs that meet the needs for such continuing education,

"(4) develop and maintain a system that provides close supervision of Community Health Representatives,

"(5) develop a system under which the work of Community Health Representatives is reviewed and evaluated,

"(6) ensure that the provision of health care, health promotion, and disease prevention activities are consistent with the traditional health care practices and cultural values of the Indian tribes served by such Program.".

TITLE II—HEALTH SERVICES

IMPROVEMENT OF INDIAN HEALTH STATUS

SEC. 201. (a) Section 201 is amended to read as follows:

"INDIAN HEALTH CARE IMPROVEMENT FUND

"SEC. 201. (a)(1) To further implement the national policy of raising the health status of Indians to a zero level of deficiency as defined in subsection (c) by eliminating backlogs in health care services and meeting unmet Indian health needs as soon as possible and in an equitable manner, the Secretary is authorized to expend, through the Service, over the 4-year period beginning with fiscal year 1986 the amounts authorized to be appropriated by subsection (h) of this section. Funds requested under this section shall be separately stated in the Service budget request as submitted to Congress under section 1105 of title 31, United States Code, and funds appropriated under this section shall not be used to offset or limit appropriations made to the Service under authority of the Act of November 2, 1921 (25 U.S.C. 13) or any other law. Funds appropriated under this section in any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

"(2) Nothing in this section is intended to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs of the Service, nor is it intended to discourage the Service from undertaking additional efforts to achieve parity among tribes.

"(b)(1) Funds appropriated under this section shall be expended to augment the ability of the Service to meet the following health service responsibilities—

"(A) clinical care (direct or indirect);

"(B) preventive health;

"(C) dental care (direct or indirect);

"(D) mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional Indian practitioners;

"(E) emergency medical services;

"(F) treatment and control of, and rehabilitative care related to, alcoholism among Indians; and

"(G) maintenance and repair.

"(2) Where any funds allocated to a tribe or service unit are used for a contract under the Indian Self-Determination and Education Assistance Act, not more than 15 percent of such funds shall be used for health planning, training, technical assistance, and other administrative support functions.

"(3) To the extent that all or a portion of the funds appropriated under subsection (h) are required to raise tribes which are below a Level II deficiency, as defined in subsection (c)(2), to such level, such funds shall not be available for allocation to tribes at or above such level. Funds appropriated under this section may be allocated on a service unit basis but must be used by each service unit to raise the deficiency level of each tribe served by such service unit. Apportionment of a tribe's or service unit's allocation of funds among the health service responsibilities listed in paragraph

(1) shall be determined by the Service and the affected Indian tribes.

"(c)(1) Within 60 days of the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall submit to the Congress the current health services priority system report of the Service for each tribe or service unit including service units serving newly recognized or acknowledged tribes. Such report shall contain—

"(A) the methodology for determining tribal health resources deficiencies; the level of health resources deficiency for each tribe; the amount of funds necessary to raise all tribes below a Level II deficiency to a Level II deficiency; the amount of funds necessary to raise all tribes below a Level I deficiency to a Level I deficiency; and the amount of funds necessary to raise all tribes to a zero level of deficiency; and

"(B) an estimate of—

"(i) the amount of health service funds appropriated under the authority of this or any other Act for the preceding fiscal year which is allocated to each service unit, tribe, or comparable entity; and

"(ii) the number of Indians eligible for health services in each service unit or tribe.

"(2) For purposes of this section, the health resources deficiency levels of a tribe are as follows:

"Level I—0 to 20 percent deficiency,

"Level II—21 to 40 percent deficiency,

"Level III—41 to 60 percent deficiency,

"Level IV—61 to 80 percent deficiency, and

"Level V—81 to 100 percent deficiency.

"(3) The Secretary shall establish by regulation procedures which allow any Indian tribe to petition the Secretary for a review of any determination of the health resources deficiency level of such tribe.

"(d) Upon enactment of the Indian Health Care Amendments of 1985, the Secretary, acting through the Service, shall take all necessary action, in cooperation with each Indian tribe, to bring current the tribal specific health plans which were developed as a part of the plan required by section 703 and which formed the basis for such plan in response to the requirements of section 701. These plans shall be based upon the methodology submitted under subsection (c), as may be further modified through tribal consultation, and shall form the basis for the health services priority system report to be submitted by the Secretary for fiscal years 1986, 1987, 1988, and 1989. Such reports shall be submitted to the Congress not more than thirty days after the submission of the annual budget for such fiscal years to the Congress by the President.

"(e) The Secretary, acting through the Service, shall expend directly or by contract, including contracts under the Indian Self-Determination and Education Assistance Act (Public Law 93–638), not less than 1 percent of the funds appropriated under subsection (h) for research in the areas of Indian health care set out in subparagraphs (A) through (F) of subsection (b)(1).

"(f) Programs administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for funds appropriated pursuant to subsection (h) on an equal basis with programs that are administered directly by the Indian Health Service.

"(g) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each fiscal year a separate statement which specifies the total amount obligated or expended in the most recently completed fiscal year to carry out subsection (d) and to carry out each of the subparagraphs of subsection (b)(1).

"(h) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

"(1) $29,000,000 for fiscal year 1986,

"(2) $28,000,000 for fiscal year 1987,

"(3) $46,000,000 for fiscal year 1988, and

"(4) $46,000,000 for fiscal year 1989.

Any funds appropriated under this subsection shall be designated as the 'Indian Health Care Improvement Fund'.".

(b) Section 4 (25 U.S.C. 1603) is amended by striking out subsections (i), (j), and (k), and by inserting in lieu thereof the following new subsections:

"(i) 'Area office' means an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographical area; and

"(j) 'Service unit' means an administrative entity within the Indian Health Service or a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act through which services are provided, directly and by contract, to the eligible Indian population within a defined geographic area.".

CATASTROPHIC HEALTH PROGRAM

Sec. 202. Title II is amended by adding at the end thereof the following new section:

"CATASTROPHIC HEALTH EMERGENCY FUND

"Sec. 202. (a) There is established an Indian Catastrophic Health Emergency Fund (hereinafter in this section referred to as the 'Fund') to be administered by the Secretary, acting through the Service, solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses falling within the responsibility of the Service. The Fund shall be administered by the central office of the Service and shall not be allocated, apportioned, or delegated on a service unit or area office basis. Funds appropriated under subsection (c) shall not be used to offset or limit appropriations made to the Service under authority of the Act of November 2, 1921 (25 U.S.C. 13) or any other law. No part of the Fund or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act (Public Law 93-638).

"(b) The Secretary shall, through the promulgation of regulations consistent with the provisions of this section—

"(1) establish a definition of disasters and catastrophic illnesses for which the cost of treatment, whether provided under contract or directly by the Service, would qualify for payment from the Fund; and which shall provide that a service unit shall not be eligible for reimbursement for the cost of treatment from the Fund until its cost of treating any victim of such catastrophic illness or disaster shall have reached a certain threshold cost which the Secretary shall establish at not less than $10,000 or not more than $20,000;

"(2) establish a procedure for the reimbursement of service units or facilities rendering treatment or, whenever otherwise authorized by the Service, the reimbursement of non-Service facilities or providers rendering treatment;

"(3) establish a procedure for payment from the Fund where the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

"(4) establish a procedure that will assure that no payment shall be made from the Fund to any provider to the extent that the provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible or by which the patient is covered.

"(c) There are authorized to be appropriated for the purpose of carrying out the provisions of this section—

(1) $12,000,000 for fiscal year 1986, and

(2) for each of the fiscal years 1987, 1988, and 1989, such sums may be necessary to maintain the Fund at $12,000,000.

Funds appropriated under this subsection shall remain available until expended.

COMPETITIVE PROCUREMENT

SEC. 203. Title II is amended by adding at the end thereof the following new section:

"COMPETITIVE PROCUREMENT

"SEC. 203. (a) Notwithstanding any other provision of law, the Secretary, acting through the Service, may waive any statutory or administrative requirement for competitive procurement of health services if, in the judgment of the Chief Medical Officer who will have jurisdiction over such health services, such competitive procurement would compromise the accessibility, quality, and continuity of health services or would not result in any appreciable competition or savings.

"(b) Notwithstanding any other provision of law, the Secretary, acting through the Service, shall reject any bid submitted under any statutory or administrative requirement for competitive procurement of health services upon the certification of the Chief Medical Officer who will have jurisdiction over such health services that acceptance of such bid would compromise the accessibility, quality, and continuity of health services.".

HEALTH PROMOTION AND DISEASE PREVENTION

SEC. 204. (a) The Congress finds that—

(1) health promotion and disease prevention activities will—

(A) improve the health and well being of Indians, and

(B) reduce the expenses for medical care of Indians,

(2) health promotion and disease prevention activities should be undertaken by the coordinated efforts of Federal, State, local, and tribal governments, and

(3) in addition to the provision of primary health care, the Indian Health Service should provide health promotion and disease prevention services to Indians.

(b) Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603), as amended by section 201(b) of this Act, is amended by adding at the end thereof the following new subsections:

"(k) 'Health promotion' includes—

"(1) cessation of tobacco smoking,

"(2) reduction in the misuse of alcohol and drugs,

"(3) improvement of nutrition,

"(4) improvement in physical fitness, and

"(5) control of stress.

"(l) 'Disease prevention' includes—

"(1) immunizations,

"(2) control of high blood pressure,

"(3) control of sexually transmittable diseases,

"(4) family planning,

"(5) pregnancy and infant care,

"(6) control of toxic agents,

"(7) occupational safety and health,

"(8) accident prevention,

"(9) fluoridation of water, and

"(10) control of infectious agents.".

(c) Title II (25 U.S.C. 1621, et seq.) is amended by adding at the end thereof the following new section:

"HEALTH PROMOTION AND DISEASE PREVENTION SERVICES

"SEC. 204. (a) The Secretary, acting through the Service, shall provide health promotion and disease prevention services to Indians.

"(b) The Secretary shall include in each health services priority system report which is required under section 201(d) an evaluation of—

"(1) the health promotion and disease prevention needs of Indians identified in tribal specific health plans,

"(2) the health promotion and disease prevention activities which would best meet such needs,

"(3) the resources which would be required to enable the Service to undertake the health promotion and disease prevention activities necessary to meet such needs,

"(4) the resources currently available to the Service which could be used to undertake such activities.

"(b) Under regulations, the Secretary shall require that each Indian tribe include within any tribal specific health plan that such tribe is required to submit to the Secretary a comprehensive plan developed by such tribe for health promotion and disease prevention among members of such tribe.

"(c) The Secretary, acting through the Service, shall—

"(1) develop from tribal specific health plans a comprehensive plan for the provision by the Service of health promotion and disease prevention services to Indians, and

"(2) establish a schedule for the provision of health promotion and disease prevention services by the Service.".

TITLE III—HEALTH FACILITIES

Sec. 301. Section 301 (25 U.S.C. 1631) is amended to read as follows:

"HEALTH FACILITIES

"Sec. 301. (a)(1) Within sixty days after the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall submit to the Congress a report which shall set forth the current health facilities priority system of the Service and which shall include the planning, design, construction, or renovation needs for the ten top priority inpatient care facilities and the ten top priority ambulatory care facilities together with required staff quarters, the justification for such priority listings, and the projected cost of such projects. The report shall also include the methodology adopted by the Service in establishing priorities under its health facilities priority system.

"(2)(A) Within thirty days of the submission of the annual budget to the Congress by the President for each of the fiscal years 1986, 1987, 1988, and 1989, the Secretary shall submit to the Congress a report which complies with the requirements of paragraph (1).

"(B) In preparing such report in such fiscal years, the Service shall consult with tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities with funds from the Service under the Indian Self-Determination Act, and shall review the needs of these tribes and tribal organizations for inpatient and outpatient facilities, including their needs for renovation and expansion of existing facilities.

"(3) The Service shall use the same criteria for each of the fiscal years 1986, 1987, 1988, and 1989 to evaluate the needs of facilities operated under contract under the Indian Self-Determination Act as it uses to evaluate the needs of facilities operated directly by the Service in such fiscal years.

"(4) The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities which are the subject of a contract for health services entered into under the Indian Self-Determination and Education Assistance Act are fully and equitably integrated into the development of the health facility priority system.".

"(b)(1) All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13) for the planning, design, construction, or renovation of health facilities for the benefit of a tribe or tribes may be used for the expenses of such activities incurred by such tribe or tribes under contracts or grants under the Indian Self-Determination Act. The United States shall hold the title to any facility constructed under a grant provided under this section.

"(2) Any tribal contractor or grantee shall expend the funds described in paragraph (1) for the purpose for which appropriated pursuant to rules and regulations established by the Secretary for contracting and procurement.

"(c) Prior to the expenditure of, or the making of any firm commitment to expend, any funds appropriated for facilities planning and design, construction, or renovation under the Act of November 2, 1921 (25 U.S.C. 13), the Secretary, acting through the Service, shall—

"(1) consult with any Indian tribe that would be significantly affected by such expenditure for the purpose of determining and, wherever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made, and

"(2) ensure, wherever practicable, that such facility, not later than one year after its construction or renovation, shall meet the standards of the Joint Commission on Accreditation of Hospitals.

"(d) The Secretary shall not close, under any existing authority, any Service hospital or other outpatient health care facility or any portion thereof unless he has submitted to the Congress at least one year prior to the planned closure date an evaluation of the impact of the proposed action which shall include the following factors—

"(1) accessibility of alternative health care resources for the service population;

"(2) cost-effectiveness of the closure;

"(3) quality of health care to be provided to the service population after closure;

"(4) availability of contract health care funds to maintain current levels of service; and

"(5) the views of the Indian tribe or tribes served by such facility on the planned closure.

"(e) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each of the fiscal years 1986, 1987, 1988, and 1989, planning information documents for the construction of 10 Indian health facilities which—

"(1) comply with applicable construction standards, and

"(2) have been approved by the Secretary.".

SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

SEC. 302. Section 302 (25 U.S.C. 1632) is amended to read as follows:

"SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

"SEC. 302. (a)(1) Congress finds that—

"(A) the provision of safe water supply and sanitary sewage and solid waste disposal systems is primarily a health consideration and function;

"(B) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of such facilities;

"(C) the long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing such facilities and other preventive health measures;

"(D) many Indian homes and communities still lack safe water supply and sanitary sewage and solid waste disposal facilities; and

"(E) it is in the interest of the United States and it is the policy of the United States that all Indian communities and Indian homes, new and existing, be provided with safe and adequate water supply and sanitary sewage and solid waste disposal facilities as soon as possible.

"(2) Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

"(b) Beginning in fiscal year 1986, the Secretary, acting through the Service, shall develop and begin implementation of a 10-year plan to provide safe water supply and sanitary sewage and solid waste disposal facilities to existing Indian homes and communities and to new and renovated Indian homes.

"(c)(1) Within 60 days of the date of the enactment of the Indian Health Care Amendments of 1985, the Secretary shall report to Congress on the Service's sanitation facilities priority system. The Secretary, in preparing such report, shall uniformly apply the methodology for determining sanitation deficiencies to all Indian tribes. Such report shall identify the methodology for determining sanitation deficiencies; the level of deficiency for each Indian community or tribe; the amount of funds necessary to raise all communities to a level I deficiency; and the amount of funds necessary to raise all communities or tribes to a zero level of deficiency. For the purpose of such report—

"(A) a level I deficiency means a sanitation system which complies with all applicable water supply and pollution control laws and regulations in which the defined deficiencies consist of routine replacement, repair, or maintenance needs;

"(B) a level II deficiency means a sanitation system which complies with all applicable water supply and pollution control laws and regulations in which the defined deficiencies consist of capital improvements necessary to improve the facilities to meet the needs of the communities for domestic sanitation facilities;

"(C) a level III deficiency means a sanitation system which has an inadequate or partial water supply and sewage disposal facility which does not comply with applicable water supply and pollution control laws and regulations or which has no solid waste disposal facility;

"(D) a level IV deficiency means a sanitation system which lacks either a safe water supply system or a sewage disposal system; and

"(E) a level V deficiency means the absence of a safe water supply and sewage disposal system.

Any tribe or community which lacks the operation and maintenance capability to meet pollution control laws and regulations shall be deemed to have a level III deficiency.

"(2)(A) Within 30 days of the submission of the annual budget to the Congress by the President for fiscal years 1986, 1987, 1988, and 1989, the Secretary shall submit a report to the Congress which meets the requirements of paragraph (1).

"(B) In preparing such report for each of the fiscal years 1986, 1987, 1988, and 1989, the Secretary, acting through the Service, shall consult with tribes and tribal organizations including those operating health care programs or facilities under contracts under the Indian Self-Determination and Education Assistance Act to determine the sanitation needs of each tribe.

"(d)(1) To clarify the powers conferred by subsection (a) of section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) the Secretary, acting through the Service, is authorized to provide—

"(A) financial and technical assistance to Indian tribes and communities in the establishment, training, and equipping of utility organizations to operate and maintain Indian sanitation facilities,

"(B) ongoing technical assistance and training in the management of utility organizations, and

"(C) operation and maintenance assistance for and emergency repairs to tribal sanitation facilities when necessary to avoid a health hazard or to protect the Federal investment in sanitation facilities in situations where the community or tribe or family is not financially or technically capable of performing the required emergency repairs with their own resources.

"(2)(A) This section is not intended to diminish the primary responsibilities of the Indian family, community, or tribe to establish, collect, and utilize reasonable user fees, or otherwise set aside funding, for the purpose of operation and maintenance of sanitation facilities.

"(B) The financial and technical capability of an Indian tribe or community to safely operate and maintain a sanitation facility shall not be a precondition for the provision or construction of such facilities and the Secretary may not require a tribe or community to accept a transfer of such facilities where he has determined the tribe or community does not have, or may not be reasonably expected to achieve, such capability.

"(e) Programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for—

"(1) funds appropriated pursuant to subsection (f), and

"(2) funds appropriated for the purpose of providing water supply or sewage disposal services,

on an equal basis with programs that are administered directly by the Indian Health Service.

"(f)(1) There are authorized to be appropriated for each of the fiscal years 1986, 1987, 1988, and 1989, $5,000,000 for the purpose of providing funds necessary to implement the expanded responsibilities of the Service under subsection (d).

"(2) In addition to the amount authorized under paragraph (1), there are authorized to be appropriated for each of the fiscal years 1986, 1987, 1988, and 1989, $850,000 for the purpose of providing 30 new full-time equivalents for the Service which shall be used to carry out the expanded responsibilities of the Service under subsection (d).".

USE OF NON-SERVICE FUNDS FOR RENOVATION

SEC. 303. Section 305 (25 U.S.C. 1634) is amended to read as follows:

"EXPENDITURE OF NON-SERVICE FUNDS FOR RENOVATION

"SEC. 305. (a) Notwithstanding any other provision of law, an Indian tribe is authorized to expend—

"(1) any funds of such tribe which are not held in trust by the Secretary of the Interior,

"(2) upon approval of the Secretary of the Interior, any funds held in trust by the Secretary of the Interior for the benefit of such tribe, and

"(3) any funds appropriated under Federal law which are not appropriated to the Secretary for expenditure through the Service,

for the purpose of making any major renovation or modernization of any Service facility or of any other Indian health facility operated pursuant to a contract entered into under the Indian Self-Determination and Education Assistance Act (including an expenditure for the planning or designing of such renovation or modernization) if the requirements of subsection (b) are met.

"(b) The requirements of this subsection are met with respect to any renovation or modernization if the renovation or modernization—

"(1) does not require or obligate the Secretary to provide any additional employees or equipment,

"(2) is approved by the appropriate area director of the Service, and

"(3) is administered by the Indian tribe in accordance with the rules and regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

"(c) A renovation or modernization shall not be authorized by this section if such renovation or modernization would require the diversion of funds appropriated to the Service from any project which has a higher priority under the health facility priority system of the Service.".

TITLE IV—ACCESS TO HEALTH SERVICES

GRANTS AND CONTRACTS WITH TRIBAL ORGANIZATIONS

SEC. 401. (a) Section 404 (25 U.S.C. 1622) is amended—

(1) by striking out "and" at the end of subsection (a)(2) and inserting in lieu thereof "or", and

(2) by striking out "shall include, but are not limited to," in subsection (b) and inserting in lieu thereof "may include, as appropriate,", and

(3) by adding "or" at the end of subsection (b)(3).

(b) Section 404(c) (25 U.S.C. 1622(c)) is amended by striking out "and" after "1983," and by inserting before the period a comma and "$1,500,000 for the fiscal year ending September 30, 1986, $2,000,000 for the fiscal year ending September 30, 1987, $500,000 for the fiscal year ending

September 30, 1988, and $500,000 for the fiscal year ending September 30, 1989.".

MEDICARE PROVISIONS

SEC. 402. (a) Section 1880 of the Social Security Act is amended—

(1) in subsection (a), by striking out "A hospital or skilled nursing facility" and inserting in lieu thereof "A provider of services or a rural health clinic";

(2) in subsection (a), by striking out "hospitals or skilled nursing facilities (as the case may be)" and inserting in lieu thereof "facilities of that type";

(3) in subsection (b), by striking out "a hospital or skilled nursing facility" and inserting in lieu thereof "a provider of services or a rural health clinic";

(4) in subsection (b), by striking out "hospitals or skilled nursing facilities (as the case may be)" and inserting in lieu thereof "facilities of that type";

(5) in subsection (c), by striking out "any hospital or skilled nursing facility" and inserting in lieu thereof "any provider of services or rural health clinic";

(6) in subsection (c), by striking out "hospitals and skilled nursing facilities" each place it appears and inserting in lieu thereof in each instance "providers of services and rural health clinics"; and

(7) in subsection (d), by striking out "hospitals and skilled nursing facilities" and "hospitals and facili-

ties", and inserting in lieu thereof in each instance "providers of services and rural health clinics".

(b) Section 1880(c) of the Social Security Act is further amended—

(1) by inserting after the first sentence the following: "In making payments from such fund, the Secretary shall ensure that each service unit of the Indian Health Service receives at least 50 percent of the amounts to which the providers and rural health clinics of the Indian Health Service, for which such service unit makes collections, are entitled by reason of this section, if such amount is necessary for the purpose of making improvements in such providers and rural health clinics in order to achieve compliance with the conditions and requirements of this title."; and

(2) by striking out "The preceding sentence" and inserting in lieu thereof "This subsection".

(c) The amendments made by this section shall apply to services performed on or after the date of the enactment of this Act.

MEDICAID PROVISIONS

SEC. 403. (a) Section 1911 of the Social Security Act is amended by striking out "or skilled nursing facility" each place it appears and inserting in lieu thereof in each instance "skilled nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan".

(b) Section 1911 of the Social Security Act is amended by adding at the end thereof the following new subsections:

"(c) The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Service facilities to Indians who are eligible for medical assistance under the State plan.

"(d) Notwithstanding any other provision of law, payments to which any facility of the Indian Health Service (including a hospital, intermediate care facility, skilled nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan) is entitled under a State plan approved under this title by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this title. In making payments from such fund, the Secretary shall ensure that each service unit of the Indian Health Service receives at least 50 percent of the amounts to which the facilities of the Indian Health Service, for which such service unit makes collections, are entitled by reason of this section, if such amount is necessary for the purpose of making improvements in such facilities in order to achieve compliance with the conditions and requirements of this title. This subsection shall cease to apply when the Secretary determines and certifies that substantially all of the health facilities of such Service in the United States are in compliance with such conditions and requirements.".

(c) Subsections (b) and (c) of section 402 of the Indian Health Care Improvement Act (42 U.S.C. 1396j, note) are repealed.

(d) The amendments made by this section shall apply to services performed on or after the date of the enactment of this Act.

DEMONSTRATION PROGRAM; STUDY

SEC. 404. Title IV is amended by adding at the end thereof the following new sections:

"DEMONSTRATION PROGRAM FOR DIRECT BILLING OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS

"SEC. 405. (a) The Secretary shall establish a demonstration program under which Indian tribes, tribal organizations, and Alaska Native health organizations, which are contracting the entire operation of an entire hospital or clinic of the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act, shall directly bill for, and receive payment for, health care services provided by such hospital or clinic for which payment is made under title XVIII of the Social Security Act (medicare), under a State plan for medical assistance approved under title XIX of the Social Security Act (medicaid), or from any other third-party payor. The Federal medical assistance percentage under the medicaid program shall continue to be 100 percent for purposes of the demonstration program.

"(b)(1) Each hospital or clinic participating in the demonstration program described in subsection (a) shall be reimbursed directly under the medicare and medicaid programs for services furnished, without regard to the provisions of sections 1880(c) and 1911(d) of the Social Security Act, but all funds so reimbursed shall first be used by the hospital or clinic for the purpose of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of such type under the medicare or medicaid program. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions or requirements shall be used in accordance with the regulations of the Indian Health Service applicable to funds provided by the Indian Health Service under any contract entered into under the Indian Self-Determination Act.

"(2) The amounts paid to the hospitals and clinics participating in the demonstration program described in subsection (a) shall be subject to all auditing requirements applicable to programs administered directly by the Indian Health Service and to facilities participating in the medicare and medicaid programs.

"(3) The Secretary shall monitor the performance of hospitals and clinics participating in the demonstration program described in subsection (a), and shall require such hospitals and clinics to submit reports on the program to the Secretary on a quarterly basis (or more frequently if the Secretary deems it to be necessary).

"(4) Notwithstanding sections 1880(c) and 1911(d) of the Social Security Act, no payment may be made out of the special fund described in sections 1880(c) or 1911(d) of the Social Security Act for the benefit of any hospital or clinic which is participating in the demonstration program described in subsection (a).

"(c)(1) In order to be considered for participation in the demonstration program described in subsection (a), a hospital or clinic must submit an application to the Secretary which establishes to the satisfaction of the Secretary that—

"(A) the Indian tribe or Alaska Native health organization contracts the entire operation of the Indian Health Service facility;

"(B) the facility is eligible to participate in the medicare and medicaid programs under sections 1880 and 1911 of the Social Security Act;

"(C) the facility meets any requirements which apply to programs operated directly by the Indian Health Service; and

"(D) the facility is accredited by the Joint Commission on Accreditation of Hospitals, or has submitted a plan, which has been approved by the Secretary, for achieving such accreditation prior to October 1, 1987.

"(2) From among the qualified applicants, the Secretary shall, prior to October 1, 1986, select no more than 4 facilities to participate in the demonstration program described in subsection (a). The demonstration program described in subsection (a) shall begin by no later than October 1, 1987, and end on September 30, 1989.

"(d)(1) Upon the enactment of the Indian Health Care Amendments of 1985, the Secretary, acting through the Indian Health Service, shall commence an examination of—

"(A) any administrative changes which may be necessary to allow direct billing and reimbursement under the demonstration program described in subsection (a), including any agreements with States which may be necessary to provide for such direct billing under the medicaid program; and

"(B) any changes which may be necessary to enable participants in such demonstration program to provide to the Indian Health Service medical records information on patients served under such demonstration program which is consistent with the medical records information system of the Service.

"(2) Prior to the commencement of the demonstration program described in subsection (a), the Secretary shall implement all changes required as a result of the examinations conducted under paragraph (1).

"(3) Prior to October 1, 1986, the Secretary shall determine any accounting information which a participant in the demonstration program described in subsection (a) would be required to report and shall provide funding for the development of any such accounting system by any facility which has been selected to participate in such demonstration program.

"(e) The Secretary shall submit an interim report to the Congress at the end of fiscal year 1988, and a final report at the end of fiscal year 1989, on the activities carried out under the demonstration program described in subsection (a), and an evaluation of whether such activities have fulfilled the objectives of such program. In the final report the Secretary shall provide a recommendation, based upon the results of such demonstration program, as to whether direct billing of, and reimbursement by, the medicare and medicaid programs and other third-party payors should be authorized for all Indian tribes and Alaska Native health organizations which are contracting the entire operation of a facility of the Indian Health Service.

"(f) The Secretary shall provide for the retrocession of any contract entered into between a participant in the demonstration program described in subsection (a) and the Indian Health Service under the authority of the Indian Self-Determination and Education Assistance Act. All cost accounting and billing authority shall be retroceded to the Secretary upon the Secretary's acceptance of a retroceded contract.

"STUDY OF BARRIERS TO PARTICIPATION

"SEC. 406. (a) The Secretary shall, in consultation with Indian tribes and tribal organizations, conduct a study of any barriers which may exist to the participation of Indians in programs established under title XVIII of the Social Security Act (medicare) or under title XIX of the Social Security Act (medicaid).

"(b) By no later than the date which is 1 year after the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall submit to the Congress a report on the study conducted under subsection (a). Such report shall include—

"(1) recommendations for legislation which—

"(A) would remove any barriers to participation identified in such study, and

"(B) would encourage participation by Indians in the programs described in subsection (a); and

"(2) estimates by service unit of—

"(A) the potential number of Indians eligible for medicare,

"(B) the potential number of Indians eligible for medicaid,

"(C) the number of Indians participating in the medicare program, and

"(D) the number of Indians participating in the medicaid program.".

TITLE V—URBAN INDIAN HEALTH SERVICES

REVISION OF PROGRAM

SEC. 501. Title V (25 U.S.C. 1651, et seq.) is amended to read as follows:

"TITLE V—HEALTH SERVICES FOR URBAN INDIANS

"PURPOSE

"SEC. 501. The purpose of this title is to encourage the establishment of programs in urban centers to make health services more accessible to urban Indians.

"CONTRACTS WITH URBAN INDIAN ORGANIZATIONS

"SEC. 502. Under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, through the Service, shall enter into contracts with urban Indian organizations to assist such organizations in the establishment and administration, within the urban centers in which such organizations are situated, of programs which meet the requirements set forth in this title. The Secretary, through the Service, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract which the Secretary enters into with any urban Indian organization pursuant to this title.

"CONTRACTS FOR THE PROVISION OF HEALTH CARE OR REFERRAL SERVICES

"SEC. 503. (a) Under authority of the Act of November 2, 1921 (25 U.S.C. 13), popularly known as the Snyder Act, the Secretary, through the Service, shall enter into contracts with urban Indian organizations for the provision of health care or referral services for urban Indians residing in the urban centers in which such organizations are situated. Any such contract shall include requirements that the urban Indian organization successfully undertake to—

"(1) determine the population of urban Indians residing in the urban center in which such organization is situated who are or could be recipients of health care or referral services;

"(2) determine the current health status of urban Indians residing in such urban center;

"(3) determine the current health care needs of urban Indians residing in such urban center;

"(4) identify all public and private health services resources within such urban center which are or may be available to urban Indians;

"(5) determine the use of public and private health services resources by the urban Indians residing in such urban center;

"(6) assist such health services resources in providing services to urban Indians;

"(7) assist urban Indians in becoming familiar with and utilizing such health services resources;

"(8) provide basic health education to urban Indians;

"(9) establish and implement manpower training programs to accomplish the referral and education tasks set forth in clauses (6) through (8) of this subsection;

"(10) identify gaps between unmet health needs of urban Indians and the resources available to meet such needs;

"(11) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians; and

"(12) where necessary, provide, or enter into contracts for the provision of, health care services for urban Indians.

"(b) The Secretary, through the Service, shall by regulation prescribe the criteria for selecting urban Indian organizations to enter into contracts under this section. Such criteria shall, among other factors, include—

"(1) the extent of unmet health care needs of urban Indians in the urban center involved;

"(2) the size of the urban Indian population in the urban center involved;

"(3) the accessibility to, and utilization of, health care services (other than services provided under this title) by urban Indians in the urban center involved;

"(4) the extent, if any, to which the activities set forth in subsection (a) would duplicate—

"(A) any previous or current public or private health services project in an urban center that was or is funded in a manner other than pursuant to this title; or

"(B) any project funded under this title;

"(5) the capability of an urban Indian organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary under this section;

"(6) the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under this title;

"(7) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an urban center; and

"(8) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

"CONTRACTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS

"SEC. 504. (a) Under authority of the Act of November 2, 1921 (25 U.S.C 13), popularly known as the Snyder Act, the Secretary, through the Service, may enter into contracts with urban Indian organizations situated in urban centers for which contracts have not been entered into under section 503. The purpose of a contract under this section shall be the determination of the matters described in subsection (b)(1) in order to assist the Secretary in assessing the health status and health care needs of urban Indians in the urban center involved and determining whether the Secretary should enter into a contract under section 503 with the urban Indian organization with which the Secretary has entered into a contract under this section.

"(b) Any contract entered into by the Secretary under this section shall include requirements that—

"(1) the urban Indian organization successfully undertake to—

"(A) document the health care status and unmet health care needs of urban Indians in the urban center involved;

"(B) with respect to urban Indians in the urban center involved, determine the matters described in clauses (2), (3), (4), and (8) of section 503(b); and

"(2) the urban Indian organization complete performance of the contract within one year after the date on which the Secretary and such organization enter into such contract.

"(c) The Secretary may not renew any contract entered into under this section.

"EVALUATIONS; CONTRACT RENEWALS

"SEC. 505. (a) The Secretary, through the Service, shall develop procedures to evaluate compliance with, and performance of, contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

"(b) The Secretary, through the Service, shall conduct an annual onsite evaluation of each urban Indian organization which has entered into a contract under section 503 for purposes of determining the compliance of such organization with, and evaluating the performance of such organization under, such contract.

"(c) If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract, attempt to resolve with such organization the areas of noncompliance or unsatisfactory performance and modify such contract to prevent future occurrences of such noncompliance or unsatisfactory performance. If the Secretary determines that such noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew such contract with such organization and is authorized to enter into a contract under section 503 with another urban Indian organization which is situated in the same urban center as the urban Indian organization whose contract is not renewed under this section.

"(d) In determining whether to renew a contract with an urban Indian organization under section 503, or whether to enter into a contract with an urban Indian organization under section 503 which has completed performance of a contract under section 504, the Secretary shall review the records of the urban Indian organization, the reports submitted under section 507, and, in the case of a renewal of a contract under section 503, shall consider the results of the on-site evaluations conducted under subsection (b).

"OTHER CONTRACT REQUIREMENTS

"SEC. 506. (a) Contracts with urban Indian organizations entered into pursuant to this title shall be in accordance with all Federal contracting laws and regulations except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935, as amended.

"(b) Payments under any contracts pursuant to this title may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this title.

"(c) Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title, except that whenever an urban Indian organization requests retrocession of the Secretary for any contract entered into pursuant to this title, such retrocession shall become effective upon a date specified by the Secretary not more than one hundred and twenty days from the date of the request by the organization or at such later date as may be mutually agreed to by the Secretary and the organization.

"(d) In connection with any contract entered into pursuant to this title, the Secretary may permit an urban Indian organization to utilize, in carrying out such contract, existing facilities owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for the use and maintenance of such facilities.

"(e) Contracts with urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts by such organizations.

"REPORTS AND RECORDS

"SEC. 507. (a) For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract entered into pursuant to this title, such organization shall submit to the Secretary a quarterly report including—

"(1) in the case of a contract under section 503, information gathered pursuant to clauses (10) and (11) of subsection (a) of such section;

"(2) information on activities conducted by the organization pursuant to the contract;

"(3) an accounting of the amounts and purposes for which Federal funds were expended; and

"(4) such other information as the Secretary may request.

"(b) The reports and records of the urban Indian organization with respect to a contract under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

"(c) The Secretary shall allow as a cost of any contract entered into under section 503 the cost of an annual private audit conducted by a certified public accountant.

"REPORTS REQUIRED

"SEC. 508. By no later than the date which is 1 year after the date of enactment of the Indian Health Care Amendments of 1985, the Secretary, through the Service, shall submit a report to Congress which assesses the health status and health care needs of urban Indians. The report shall—

"(1) specify the health care needs of urban Indians and, with respect to urban centers for which urban Indian organizations have entered into contracts under section 503, whether additional health care personnel are needed to meet such needs;

"(2) make recommendations for additional programs, technical assistance, funding, and additional health care personnel to meet the health care needs of all urban Indians; and

"(3) contain recommendations for legislation and administrative actions to achieve the national goal of providing the best possible health status for urban Indians.

"LIMITATION ON CONTRACT AUTHORITY

"SEC. 509. The authority of the Secretary to enter into contracts under this title shall be to the extent, and in an amount, provided for in appropriation Acts.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

MANAGEMENT INFORMATION SYSTEM

SEC. 601. (a) Title VI is amended to read as follows:

"TITLE VI—INDIAN HEALTH SERVICE

"MANAGEMENT INFORMATION SYSTEM; ACCESS TO PATIENT'S RECORDS

"SEC. 601. (a)(1) The Secretary shall establish an automated management information system for the Service.

"(2) The information system established under paragraph (1) shall include—

"(A) a cost accounting system,

"(B) a patient care information system for each area served by the Service,

"(C) a privacy component that protects the privacy of patient information held by, or on behalf of, the Service, and

"(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each Area office of the Service.

"(3) By no later than September 30, 1986, the Secretary shall submit a report to Congress setting forth—

"(A) the activities which have been undertaken to establish an automated management information system,

"(B) the activities, if any, which remain to be undertaken to complete the implementation of an automated management information system, and

"(C) the amount of funds which will be needed to complete the implementation of a management information system in the succeeding fiscal years.

"(b) Notwithstanding any other provision of law, each patient shall have reasonable access to the medical or health records of such patient which are held by, or on behalf of, the Service.".

(b) The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

INDIAN HEALTH SERVICE PLACED WITHIN PUBLIC HEALTH SERVICE

SEC. 602. (a) Title VI, as amended by section 601 of this Act, is further amended—

(1) by redesignating section 601 as section 602, and

(2) by inserting after the heading of the title, the following new section:

"ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE

"SEC. 601. (a) In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as is or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department of Health and Human Services the Indian Health Service. The Indian Health Service shall be administered by a Director, who shall be appointed by the President, by and with the advice and consent of the Senate. The Director of the Indian Health Service shall report to the Secretary through the Assistant Secretary of Health and Human Services for Health, and shall not report to, or be under the supervision of, any other officer or employee of the Department of Health and Human Services.

"(b) The Indian Health Service shall be an agency within the Public Health Service of the Department of Health and Human Services, and shall not be an office, component, or unit of any other agency of the Department.

"(c) The Secretary shall carry out through the Director of the Indian Health Service—

"(1) all functions which were, on the day before the date of enactment of the Indian Health Care Amendments of 1985, carried out by or under the direction of the individual serving as Director of the Indian Health Service on such day;

"(2) all functions of the Secretary or the Department of Health and Human Services relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and the provision and utilization of, health services for Indians; and

"(3) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including (but not limited to) programs under—

"(A) this Act;

"(B) the Act of November 2, 1921 (25 U.S.C. 13);

"(C) the Act of August 5, 1954 (68 Stat. 674);

"(D) the Act of August 16, 1957 (71 Stat. 370);

"(E) the Indian Self-Determination and Education Assistance Act (Public Law 93-638); and

"(F) the Act of December 5, 1979 (93 Stat. 1056).

"(d)(1) Notwithstanding any other provision of law, the Secretary may not reorganize, alter, or discontinue the Indian Health Service or allocate or reallocate any function which this section specifies shall be performed by the Director of the Indian Health Service or by the Secretary of Health and Human Services through the Director of the Indian Health Service.

"(2) Paragraph (1) shall not apply to any action taken by the Director of the Indian Health Service which the Director of the Indian Health Service determines to be appropriate.

"(e)(1) The Director of the Indian Health Service shall have the authority—

"(A) except to the extent provided in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

"(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

"(C) to manage, expend, and obligate all funds appropriated for the Service.

"(2) The provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), but not the provisions of section 2 of Public Law 96–135 (25 U.S.C. 472a), shall apply to personnel actions taken with respect to positions within the Service.

"(3) The authority of the Director of the Indian Health Service to enter into contracts under this subsection shall be to such extent or in such amounts as are provided in appropriation Acts.".

(b) Section 5315 of title 5, United States Code, is amended by adding at the end thereof the following new item:

"DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES.".

(c) All personnel, records, equipment, facilities, and interests in property that are administered by the Indian Health Service on the day before the date on which the amendments made by this section take effect shall be transferred to the Indian Health Service established by the amendment made by subsection (a) of this section.

(d) By no later than August 30, 1986, the Secretary shall submit to the Congress a plan for the implementation of the amendments made by this section which takes into account—

(1) the results of any study conducted by the Office of Technology Assessment or the Comptroller General of the United States relating to the organizational structure of the Indian Health Service, and

(2) any other relevant study or information relating to the organizational structure of the Indian Health Service.

(e)(1) The requirements of section 601 of the Indian Health Care Improvement Act, as amended by this section, shall be met within 180 days after the date on which the amendments made by this section take effect.

(2) The Secretary of Health and Human Services may waive the application of the Indian preference laws during the 180-day period beginning on the date on which the amendments made by this section take effect on a case-by-case basis for any temporary transfer which is necessary in order to implement the amendments made by subsection (a) of this section.

(f) The amendments made by this section shall take effect on May 30, 1987.

TITLE VII—MISCELLANEOUS

LEASING AND OTHER CONTRACTS

SEC. 701. Section 704 (25 U.S.C. 1674) is amended—

(1) by striking out "Notwithstanding", and inserting in lieu thereof "(a) Notwithstanding", and

(2) by adding at the end thereof the following new subsection:

"(b) The Secretary may enter into leases, contracts, and other legal agreements with Indian tribes or tribal organizations which hold—

"(1) title to;

"(2) a leasehold interest in; or

"(3) a beneficial interest in (where title is held by the United States in trust for the benefit of a tribe);

facilities used for the administration and delivery of health services by the Indian Health Service or by programs operated by tribes or tribal organizations to compensate such tribes or tribal organizations for costs associated with the use of such facilities for such purposes. Such costs include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation and maintenance expenses, and other expenses determined by regulation to be allowable.".

JUVENILE ALCOHOL AND DRUG ABUSE

SEC. 702. Section 706 (25 U.S.C. 1676) is amended to read as follows:

"JUVENILE ALCOHOL AND DRUG ABUSE

"SEC. 706. (a) Within 90 days of the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall enter into an agreement with the Secretary of the Interior and the Secretary of Education to coordinate the efforts of their Departments related to alcohol and drug abuse among Indian juveniles. The agreement shall provide for the identification and coordination of available resources and programs to combat Indian juvenile alcohol and drug abuse through prevention, education, counseling, and referral. The Secretary shall publish such agreement in the Federal Register within 120 days of the date of enactment of the Indian Health Care Amendments of 1985.

"(b) The Secretary, acting through the Service and in consultation and cooperation with the Secretary of the Interior and the Secretary of Education, shall develop a program to provide training in—

"(1) preventive education;

"(2) the identification of juvenile alcohol and drug abusers; and

"(3) counseling techniques on juvenile alcohol and drug abuse.

Such training shall be provided to elementary and secondary teachers and counselors—

"(A) in schools operated by the Bureau of Indian Affairs;

"(B) in schools operated under contract with the Bureau of Indian Affairs; and

"(C) in public schools on or near Indian reservations (including public schools in Oklahoma and Alaska with significant numbers of Indian students).

The Service may provide such training either directly or through contract with qualified private or public entities.

"(c) The Secretary of the Interior, acting through the Bureau of Indian Affairs and in consultation with the Service, shall review existing literature and reports on juvenile alcohol and drug abuse, including studies and school curricula and any other material relevant to an understanding of the problem of juvenile alcohol and drug abuse, and shall make available the results of such review to the schools described in subsection (b).

"(d) The Secretary shall establish an Office of Alcohol and Drug Abuse within the Service which shall be responsible for the administration of the programs and authorities of the Service in the field of alcohol and drug abuse. The Office shall have assigned to it a number of full-time equivalent positions which shall be not less than eight full-time equivalent positions in the Central Office of the Service and one full-time equivalent position in each Service area and Program Office.

"(e) For the purpose of implementing subsection (b), there are authorized to be appropriated $1,500,000 for each of the fiscal years 1986, 1987, 1988, and 1989.".

NUCLEAR RESOURCE DEVELOPMENT HEALTH HAZARDS

SEC. 703. (a) Subsections (a) and (b) of section 707 (25 U.S.C. 1677) are amended to read as follows:

"(a) The Secretary, acting through the Service, shall enter into appropriate arrangements with the National Academy of Sciences, in consultation with the Office of Technology Assessment, to conduct a study of the health hazards to Indian miners and to Indians living on, or near Indian reservations or in Indian communities which result from development of nuclear resources. Such study shall include—

"(1) an evaluation of the nature and extent of nuclear resource development related health problems currently exhibited among Indians and the causes of such health problems;

"(2) an analysis of the potential effect of ongoing and future nuclear resource development on or near Indian reservations and communities;

"(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems, including uranium mining and milling, uranium mine tailing deposits, nuclear powerplant operation and construction, and nuclear waste disposal;

"(4) a summary of any findings and recommendations provided in Federal and State studies, reports, investigations, and inspections during the 10-year period ending on the date of enactment of the Indian Health Care Amendments of 1985 that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

"(5) an evaluation of the efforts that have been made by Federal and State agencies and mining and milling companies to effectively carry out an education program for such Indians regarding the health and safety hazards of nuclear resource development.

To assist the Academy in conducting such study, the Secretary and the Secretary of the Interior shall furnish at the request of the Academy any information which the Academy deems necessary for the purpose of conducting the study. In addition, they shall cooperate with the Academy in obtaining information necessary to carry out the intent of the study.

"(b) Upon the completion of the study described in subsection (a), the Secretary, acting through the Service, shall develop, on the basis of the results of such study, a health care plan to address the health problems studied under subsection (a). The plan shall include—

"(1) methods for diagnosing and treating Indians currently exhibiting nuclear resource development related health problems;

"(2) preventive care for Indians who may be exposed to such health hazards as a result of nuclear resource development, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation, or otherwise affected by nuclear development activities that have had or could have a serious impact upon the health of such individuals; and

"(3) a program of education for Indians who, by reason of their work or geographic proximity to nuclear development activities, may experience health problems.".

(b) Subsection (c) of section 707 is amended by striking out "no later than the date eighteen months after the date of the enactment of this Act" and inserting in lieu thereof "by no later than the date which is 18 months after the date of enactment of the Indian Health Care Amendments of 1985".

(c) Subsection (f) of section 707 (25 U.S.C. 1677 (f)) is amended to read as follows:

"(f) There are authorized to be appropriated $750,000 for the purpose of conducting the study described in subsection (a). Such funds shall remain available for expenditure until the date which is 18 months after the date such funds are appropriated.".

ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA; FORMERLY RECOGNIZED TRIBES IN CALIFORNIA

SEC. 704. (a)(1) Subsection (a) of section 708 (25 U.S.C. 1678 (a)) is amended—

(A) by striking out "1984" and inserting in lieu thereof "1989", and

(B) by striking out "Indians in such State" and inserting in lieu thereof "members of federally recognized Indian tribes of Arizona".

(2) Subsection (c) of section 708 (25 U.S.C. 1678(c)) is amended to read as follows:

"(c) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section."

ELIGIBILITY OF CALIFORNIA INDIANS

SEC. 705. Section 709 (25 U.S.C. 1679) is amended to read as follows:

"ELIGIBILITY OF CALIFORNIA INDIANS

"SEC. 709. The following California Indians shall be eligible for care from the Service:

"(1) Any Member of a federally recognized Indian tribe.

"(2) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant—

"(A) is living in California,

"(B) is a member of the Indian community served by a local program of the Service, and

"(C) is regarded as an Indian by the community in which such descendant lives.

"(3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

"(4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

Paragraph (4) shall not apply after September 30, 1988.".

CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

SEC. 706. Section 710 (25 U.S.C. 1680) is amended to read as follows:

"CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA

"SEC. 710. The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, and Santa Clara, shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to Indians in such State.".

CONTRACT HEALTH FACILITIES

SEC. 707. (a) Title VII is amended by adding at the end thereof the following new section:

"CONTRACT HEALTH FACILITIES

"SEC. 711. (a) The Indian Health Service shall provide funds for health care programs and facilities operated by tribes and tribal organizations under contracts with the Indian Health Service under the Indian Self-Determination Act—

"(1) for the maintenance and repair of clinics owned or leased by such tribes or tribal organizations, "(2) for employee training,

"(3) for cost-of-living increases for employees, and

"(4) for any other expenses relating to the provision of health services,

on the same basis as such funds are provided to programs and facilities operated directly by the Indian Health Service.

"(b) In the case of eligible California Indians as defined by section 709 who are not members of Indian tribes or eligible for membership in such tribes, the Secretary may not enter into a contract to provide health services to such Indians under section 103 of the Indian Self-Determination Act if 51 percent of the adult population of such Indians object prior to the award of such contract through any legally established organization of Indians representative of such Indians, in which case the Secretary, acting through the Service, shall make alternate arrangements for the delivery of health care services to such Indians. In making such alternative arrangements for such Indians, the Service may—

"(1) provide services directly to some or all of such Indians through its own facilities,

"(2) purchase services for some or all of such Indians on a contract basis,

"(3) contract with a qualified organization representing some or all of such Indians for the provision of services under the terms of the third proviso of the first paragraph under the heading "Secretary" in the division relating to general provisions of the Act of April 30, 1908 (35 Stat. 71, chapter 153; 25 U.S.C. 47), popularly known as the Buy Indian Act, or

"(4) make other effective arrangements for the delivery of health care services to such Indians.

"(c) Nothing in this section shall be construed to restrict or interfere with the right of any Indian tribe to contract for health services on behalf of its own members.".

(b)(1) The Secretary of Health and Human Services shall determine whether the provisions of subsection (b) of section 711 of the Indian Health Care Improvement Act have interfered with the effective administration of contracts entered into under section 103 of the Indian Self Determination Act (25 U.S.C. 450g).

(2) The Secretary of Health and Human Services shall submit to the Congress a report on the determination made under paragraph (1) by not later than the date that is 18 months after the date of enactment of this Act.

NATIONAL HEALTH SERVICE CORPS

SEC. 708. (a) Title VII, as amended by section 707 of this Act, is further amended by adding at the end thereof the following new section:

"NATIONAL HEALTH SERVICE CORPS

"SEC. 712. (a) The Secretary of Health and Human Services shall not—

"(1) remove a member of the National Health Service Corps from a health facility operated by the Indian Health Service or by a tribe or tribal organization under contract with the Indian Health Service under the Indian Self-Determination Act; or

"(2) withdraw funding used to support such member,

unless the Secretary, acting through the Service, has ensured that the Indians receiving services from such member will experience no reduction in services.".

(b) The amendment made by subsection (a) of this section shall take effect as of May 1, 1984.

ADDITIONAL PROVISIONS

SEC. 709. Title VII, as amended by sections 707 and 708 of this Act, is further amended by adding at the end thereof the following new sections:

"SERVICE TO INELIGIBLE PERSONS

"SEC. 713. (a)(1) The Secretary, acting through the Service, may provide or authorize the provision of medical care, treatment, or benefits by the Service to persons who are not otherwise eligible for such services in health facilities maintained by the Service or contracted under the Indian Self-Determination and Education Assistance Act (Public Law 93–638) or through contract health care services, subject to the limitations of this section.

"(2) Persons eighteen years of age or under who are the natural or adopted children (including foster- and step-children), legal wards, or orphans of an eligible Indian person and who are not otherwise eligible for the medical care, treatment, or benefits of the Service shall be eligible for all such services on the same basis and subject to the same rules as apply to eligible Indians until their nineteenth birthday. The existing and potential medical needs of such persons shall be taken into consideration by the Service in determining the need for, or the allocation of, its health resources. Any such person who has been determined to be legally incompetent prior to their nineteeth birthday shall remain eligible for such services until one year after the date such disability has been removed.

"(3) Non-Indian spouses of eligible Indians or spouses of Indian descent who are not otherwise eligible for the medical care, treatment, or benefits of the Service shall not be eligible for such service unless they are made eligible, as a class, by an appropriate resolution of the governing body of the relevant Indian tribe. The medical needs of persons made eligible under this subsection shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

"(b)(1)(A) At the request of the Indian tribe or tribes included within the service area of any service unit of the

Service, the Secretary may authorize the medical care and treatment of otherwise ineligible persons residing within such service area in health facilities maintained and operated by the Service.

"(B) Persons receiving medical care and treatment under this subsection shall be liable for the payment for such services under a fee schedule adopted by the Secretary which, in the judgment of the Secretary, shall result in reimbursement in an amount not less than the actual cost of providing the service. Fees collected under this subsection, including medicare or medicaid reimbursements under titles XVIII and XIX of the Social Security Act, shall be credited to the account of the facility providing the service and shall be used solely for the provision of health services within that facility.

"(2)(A) Except as provided in subparagraph (B), where the governing body of an Indian tribe or, in the case of a multi-tribal service area, any Indian tribe revokes its concurrence to the provision of services under paragraph (1)(A), the Secretary's authority to provide such service shall terminate at the end of the fiscal year following the fiscal year in which such revocation was adopted.

"(B) In California, in the case of a multi-tribal service area, unless 51 percent or more of the Indian tribes in the Service area revoke their concurrence to the provision of services under paragraph (1)(A), the authority to provide such service shall not be affected.

"(3)(A) In the case of health facilities operated directly by the Service, such medical care and treatment may be provided under this subsection only where the Secretary and the affected tribe or tribes have jointly determined that—

"(i) the provision of such service will not result in a denial or diminution of services to eligible Indian persons; and

"(ii) there is no reasonable alternative health facility or service, within or without the service unit area, available to meet the medical needs of such persons.

"(B) In the case of health facilities operated under contract under the Indian Self-Determination and Education Assistance Act, the governing body of the Indian tribe or tribal organization providing health services under a contract with the Service under the Indian Self-Determination Act is authorized to determine the eligibility for such services of persons who are not otherwise eligible for such services. Such determination shall be in accordance with the requirements of this section.

"(4) The Service may continue to provide medical care, treatment, and benefits to persons not provided service under subsections (a) or (b) to achieve stability in a medical emergency, to prevent the spread of a communicable disease or otherwise deal with a public health hazard; to provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post partum, or to immediate family members of an eligible person where such care is directly related to the treatment of the eligible person.

"(5) Hospital privileges in health facilities operated and maintained by the Service or operated under contract under the Indian Self-Determination and Education Assistance Act may be extended to non-Service health care practitioners under a plan adopted under subsection (d) of this section. Such non-Service health care practitioners shall not be regarded as employees of the Federal Government for purposes of sections 1346(b) and 2671 et seq. of title 28 of the United States Code relating to Federal tort claims even if providing services to eligible persons as a part of the condition under which privileges are extended.

"RESTRICTIONS ON THE USE OF INDIAN HEALTH SERVICE APPROPRIATIONS

"SEC. 714. Unless otherwise specifically provided, any restriction placed on the use of appropriations for Indian health services shall not be interpreted—

"(1) to apply to the use of funds other than such appropriated funds by an entity with a contract with the Indian Health Service;

"(2) to prohibit the support of litigation with such other funds; or

"(3) to prohibit the promotion of public support for or opposition to any legislative proposal with such other funds.

"INFANT AND MATERNAL MORTALITY

"SEC. 715. (a) Not later than January 1, 1986, the Secretary shall develop and begin implementation of a plan to achieve the following objectives by January 1, 1991:

"(1) Reduction of the rate of Indian infant mortality in each Area Office of the Service to twelve deaths per one thousand live births or to that of the United States population, whichever is lower.

"(2) Reduction of the rate of maternal mortality in each Area Office of the Service to five deaths per one hundred thousand live births or to that of the United States population, whichever is lower.

"(b) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each fiscal year a separate statement which specifies the total amount obligated or expended in the most recently completed fiscal year to achieve each of the objectives described in subsection (a).

"REDUCTION AND CONTROL OF HEPATITIS-B IN ALASKA

"SEC. 716. (a)(1) By no later than the date which is 1 year after the date of enactment of the Indian Health Care Amendments of 1985, the Secretary, through the Service and in conjunction with the State of Alaska and the Center for Disease Control, shall complete the implementation of a program to provide for—

"(A) screening and reporting of cases of,

"(B) vaccinations for the prevention of, and

"(C) control of the incidence of,

hepatitis-B in Alaska.

"(2) By no later than December 31, 1987, the Secretary shall submit to the Congress a report concerning the activities carried out under the program described in paragraph (1). The report shall include—

"(A) a description of any activities which, on the day the report is submitted, need to be carried out to control the incidence of hepatitis-B in Alaska, and

"(B) a schedule for the completion of such activities.

"(b) The Secretary shall include in the budget submitted under section 1105(a) of title 31, United States Code, for each of the fiscal years succeeding the fiscal year in which the Indian Health Care Amendments of 1985 are enacted, a request for budget authority for, and estimates of outlays for, a program to control the incidence of hepatitis-B in Alaska.

"CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA

"SEC. 717. The Secretary, acting through the Service, is directed to provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana. The Secretary is directed to conduct a population survey of Indians residing in the Trenton Service Area for the purpose of determining the basis for the distribution of equity health care funds and the provision of contract health care. Should the results of the population survey indicate that additional eligible members of the Turtle Mountain Band of Chippewa Indians reside outside the boundaries of the named North Dakota and Montana counties, the contract health service delivery area shall be defined to include those additional counties of North Dakota or Montana in which such eligible tribal members reside.".

"STUDY OF HEALTH CARE NEEDS OF NATIVE HAWAIIANS AND OTHER NATIVE PACIFIC ISLANDERS

"SEC. 718. (a)(1) The Secretary shall conduct a study of the physical and mental health care needs of Native Hawaiians and other Native American Pacific Islanders.

"(2) In conducting the study required under paragraph (1), the Secretary shall consult with the Commissioner of the Administration for Native Americans, the Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, the Director of the Indian Health Service, leaders in the field of health care, and representatives of Native Hawaiians and other Native American Pacific Islanders.

"(b) By no later than the date that is 1 year after the date of enactment of the Indian Health Care Amendments of 1985, the Secretary shall submit to the Congress a report on the study conducted under subsection (a). Such report shall include—

"(1) an assessment of the access of, and barriers to, Native Hawaiians and other Native American Pacific Islanders in receiving physical and mental health care services,

"(2) an assessment of the physical and mental health care needs of Native Hawaiians and other Native American Pacific Islanders, and

"(3) specific recommendations for the development of a national strategy to address such needs.".

SEVERABILITY

SEC. 710. If any provision of this Act, any amendment made by this Act, or the application of such provision or amendment to any person or circumstances is held to be invalid, the remainder of this Act, the amendments made by this Act, and the application of such provision to persons or circumstances other than those to which it is held invalid shall not be affected thereby.

Senator **Andrews**. Before we begin, I would also like to announce the appointment yesterday of two new Senators to the Select Committee on Indian Affairs, Senator James Abdnor of South Dakota on the majority side, and Senator Quentin Burdick of North Dakota on the minority side. This brings the strength of the select committee to nine members. I am very pleased to have both Senator Abdnor and Senator Burdick join us on this committee.

I see now that Senator Bingaman, our first senatorial witness, has appeared. Dr. Graham, stay where you are. Senator, if you will take the microphone, we will be glad to hear your testimony. Welcome to the committee.

Senator **Bingaman**. Thank you very much, Senator Andrews.

Mr. Chairman, I hate to go in front of these distinguished gentlemen here, but I will be brief. I have some testimony that I would like to submit for the record, and I will try to summarize it for the committee.

Senator **Andrews**. Fine, Senator. You may be assured that it will appear in the record in its entirety.

STATEMENT OF HON. JEFF BINGAMAN, A U.S. SENATOR FROM THE STATE OF NEW MEXICO

Senator **Bingaman**. I am particularly interested in this legislation because it includes several provisions that are of importance to me: Section 108, the continuance and improvement of the Community Health Representative Program; and section 204, the establishment of a Health Promotion and Disease Prevention Service within the Indian Health Service.

Both these provisions were proposed in S. 400 which is the Indian Health Promotion and Disease Prevention Act of 1985. I referred them in draft form to this committee and I am pleased that the committee has incorporated these into the body of S. 277. I thank the chairman for your favorable consideration of these additions, and I strongly believe that they will help strengthen the Indian Health Care bill.

Today, I want to just address a couple of aspects of Indian health care, in particular, one that I have found to be sorely neglected. Health promotion and disease prevention initiatives really are distinct from direct patient care and, in my view, in the long run will help lower the health cares costs and medical costs to American Indians. They also encourage American Indians to be more productive and to lead healthier lifestyles.

In 1979, the Surgeon General issued the landmark publication "Healthy People," setting forth a national agenda for health promotion and disease prevention. A few years later, "Objectives for the Nation" interpreted these goals and proposed a national strategy to reach them. As a result, this new component of health promotion is one that has Federal Government as well as national support. It is only appropriate, in my view, that the Indian Health Service, as one of the major Federal primary health care providers, also be part of this movement.

I am sure you are aware, Mr. Chairman, that American Indians have a lower health status than the general U.S. population. Although it is essential to deal with the problem by directing resources to primary health care, we also need to be looking to the future and establishing long term goals for how we can improve the health of American Indians.

In New Mexico, where I come from, a sizeable American Indian population exists. In my conversations with tribal leaders, Indian Health Service professionals, and health care professionals generally, they have all expressed a keen interest in encouraging better health care education and wellness among Indian people. I have found that among the various Indian communities, the pendulum swung widely between little or no effort in prevention to communitywide programs. In particular, within the Indian Health Service, the approach seems to be based on available resources and the extent of the local interest. For example, some service units provide nutrition classes, others provide health fairs, and still others stress fitness programs for employees.

Although the Indian Health Service has a budget category of preventive health, it has focused in the past only on sanitation, public health nursing, health education, community health representative program, and the hepatitis B screening and immunization program. These categories are essential and need to be continued, but in my view, we can do a great deal more.

Today, there is no national comprehensive strategy for Indian health promotion, and, in my view, the efforts that are underway are piecemeal, at best. Also, information about prevention efforts needed by tribes is lacking, and there is no clear plan on how to reduce the health risks of Indian people.

The two sections I referred to earlier, section 108 and section 204 of S. 277, seek to address these matters. I will very briefly explain how.

Section 108 continues the Community Health Representative Program and it does so with a new perspective. Under Section 108, the community health representative paraprofessionals would help serve the community care needs in the community. Quality training and rigorous curriculum would be developed with an emphasis on the theoretical and practical experience of health care and prevention, with instruction in the most effective social, educational, and behavioral approaches to good health maintenance. Continuing education is also emphasized as well as a system to evaluate and review the CHR Program. Finally the traditional health care practices and cultural values of tribes would be taken into account and, if appropriate, incorporated into the tribe's program.

The Community Health Representative Program, in my view, is really the only IHS Program that deals in health education and health promotion. I believe it should be continued and used as a purveyor of this new health promotion focus in IHS.

Section 204 of S. 277 requires the development of a health promotion and disease prevention policy and the establishment of health promotion and disease prevention services within IHS. This section defines health promotion and disease prevention to include cessation of smoking, reduction of alcohol intake, improvement of nutrition, physical fitness, immunizations, control of accidental injuries and infectious diseases, and reduction of infant mortality.

This section mandates that the Secretary, acting through the HS, shall assist tribes to include and develop their own health lans and health promotion and disease prevention strategies for heir members. It will allow the IHS to be informed on what tribes re doing nationally as well as to assist them to begin to develop heir own objectives in this area.

Section 204 further requires that from the information gathered n the tribal specific health plans, IHS will put together a compreiensive plan for health promotion and disease prevention services o be carried out by the Service. In the long term, I view this as an xtremely beneficial step, for it would be a benchmark to measure HS progress against the goals it would establish in such a compreiensive plan. This plan could be similar to that in "Objectives for he Nation," to which I referred earlier except, in this instance, it vould be objectives for the American Indian with regard to health promotion.

In closing, Mr. Chairman, I will conclude with one further remark. My bill, S. 400, specifies that a demonstration project should be established to serve as a model for health promotion. I recognize that the committee seeks to have a streamlined bill to present to the President, and I am well aware of the budget battles in which the Congress is currently involved. However, in order to carry out the purposes of the act and implement these ideals, a communitywide demonstration program is badly needed.

I would like to continue to pursue this with the committee in the coming months. Also, I understand that the Indian Health Service supports this health promotion effort. I believe there will be some technical amendments that we would like to present to the committee before it goes to markup, and I greatly appreciate your willingness to include these provisions in the bill that you are going to present to the full Senate. I think it is excellent that you are moving so quickly on this matter in this Congress.

Thank you very much.

Senator ANDREWS. Thank you, Senator, for an excellent statement. It will be most helpful to the committee, and we are looking forward to hearing any additional modifications you might have.

We have to keep in mind that the need is great for this legislation out in the field. It is imperative that we draft it in such a way that it does not get vetoed again. Because, if it does not get past the administration, we have not done anything for the individuals who have such great need for this particular piece of legislation.

So, it is good to have your support, Senator. It is great to know the needs of the people in New Mexico whom you represent so well, and we are looking forward to any further comments and suggestions you might have.

Thank you for coming.

Senator BINGAMAN. Thank you very much.

Senator ANDREWS. Doctor, we appreciate your being here. You may proceed with your statement. Let me say that it will appear in its entirety in the record. You can summarize it in any way you choose. We will be glad to hear from you and your colleagues now.

Dr. GRAHAM. Thank you, Mr. Chairman.

Senator ANDREWS. We are pleased to hear from you, Doctor.

Dr. GRAHAM. Thank you. You are very kind.

STATEMENT OF DR. ROBERT GRAHAM, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY DR. EVERETT RHOADES, DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. GRAHAM. You do have before you our full statement, and I certainly will not take time to read that.

I would simply summarize by saying that we continue to affirm that, in our view, the principles embodied by the Indian Health Care Improvement Act are really foremost in our efforts to improve the level of health of the Indian people and the Indian communities. We share your concern about the experience of the last 2 years in our efforts to work with this committee and your conferees in the House to find an acceptable bill to the President, and we regret that that was not possible. We hope that that experience can be avoided this year.

We do have some specific differences with the bill as proposed; these are detailed in my statement. We would be happy to discuss those with you in whatever depth you would like.

The only other principle that I would point out that has dictated our response to the committee's draft bill or to the committee's bill is that, of course, our response is consistent with the overall budget levels that the President is seeking in fiscal year 1986. So, it is a matter of both authority and appropriations that we will be having to deal with in our discussions this morning.

With that, sir, I realize now I have omitted introducing formally Dr. Rhoades, who is the Director of the Indian Health Service, and Mr. Bill Pearson, who is the Associate Director for Administration and Management. We would be happy to respond to any questions that you have, sir.

Senator ANDREWS. Thank you, Doctor. We appreciate that introduction. It serves well for the record and for those in attendance at this hearing. For those of us who are members of the committee, of course, we have a long working relationship with you and your colleagues.

Before we address the provisions of S. 277, we have several witnesses today who have come to express their support for the demonstration program in the State of Montana supported so avidly by my colleague, Senator Melcher. It was contained in last year's bill, as you know, and the President cited that program as one of the grounds for his veto of S. 2166. You could be most helpful, Doctor, to us, if you could enlighten us, speaking for the administration as you do, on the specific objections that the administration has to this provision.

Dr. GRAHAM. I think the best way to capsulize the objectionable elements of that provision is to say that, in my view, it is a basic step toward disenfranchising Indian individuals from a set of rights that we feel are basic to them as individuals and as members of Indian tribes. The relationship that the U.S. Government has established with the Indian people is a relationship which acknowledges their full rights and privileges as individual citizens of a given State. In addition to that, in recognition of their membership in a tribe, with which the U.S. Government has entered into a treaty obligation, there are benefits over and above that citizenship which accrue to individual Indians and Indian communities.

I believe the view of the President and the Secretary of the Department is that the provision that was proposed last year would have treated individual Indian citizens of the State of Montana differently from other citizens of that State solely on the basis of the fact that they were Indian. I do not even know, were that provision to have been signed into law, whether or not it would have stood up to a challenge under the Civil Rights Act.

But we do not even need to get into that, because I think the basic position you start out with is that the Indian individuals are citizens of the state. That means they are entitled to all benefits which are provided to citizens of the State or citizens of the county or a township. You cannot discriminate against them solely on the basis of their ancestry or the fact that other sets of benefits may also be available to them. Those sets of benefits are available because of the treaty obligations that the U.S. Government has entered into with their tribe.

Senator **Andrews**. In the BIA budget, Doctor, the President has requested $82.7 million for general welfare assistance. That program serves otherwise eligible Indians who are indigent and are not receiving assistance from public welfare agencies because these public programs are funded by the revenues from real property taxes—revenues that cannot be obtained from Indian lands because of the Federal trust status. According to the President's budget, the tax exempt status of Indian lands affects the ability of some States and counties to provide this assistance, particularly if Indians constitute a considerable portion of their population. These are the President's words, your words, really, because it is your shop.

This is precisely the justification that Congress relied upon in accepting the demonstration program as part of the Indian Health Care Act. So, the precedent, we feel, for such a program exists and has existed for years by virtue of BIA's General Welfare Assistance Program.

Dr. **Graham**. I think there is a very distinct difference in approaches there. What you have cited is the fact that the President and the BIA, recognizing that there is some impact on individual taxing authorities of a tax exempt status of an Indian reservation or Indian community, have tried to add something to the revenues available for services to those Indian individuals. The provision for the Montana experiment would have been to take services away from Indians. I think those are two profoundly different approaches.

Senator **Andrews**. Doctor, I would like at this point to put a statement in the record, a letter from Stanley Franek, the county director of the Benson County Board of Social Services, in support of the Montana concept.

That letter also includes the statement of the Montana County Welfare Director's Association. I would like to have this material inserted in the record at this point.

[The letter and statement follow:]

BENSON COUNTY BOARD OF SOCIAL SERVICES,
Minnewaukan, ND, February 20, 1985.

Senator MARK ANDREWS,
Senate Hart Office Building,
Washington, DC.

DEAR SENATOR ANDREWS: Enclosed please find a copy of a document recently received from the Montana County Welfare Director's Association. Although we in North Dakota are not impacted by the same type of problems being experienced in Montana, we do support their contention that Indian Health Services be the primary health resource for indigent Indians.

On behalf of the North Dakota County Social Service Director's Association we ask your support of Senator Melcher's action as contained in SB 277.

Thank you for your consideration and favorable response to our request.

Sincerely,

STANLEY R. FRANEK, *ACSW, County Director III.*

PREPARED STATEMENT OF THE MONTANA COUNTY WELFARE DIRECTOR'S ASSOCIATION, CAROLE A. GRAHAM, PRESIDENT

MONTANA INDIAN HEALTH CARE

The Montana County Director's Association requests the opportunity to clarify our position on an issue; one which has significance to all local governments concerned with the health care of American Indians residing on reservations created by Federal treaties. The Indian Health Care Amendment of 1984, was passed by both houses of Congress, but vetoed by President Reagan. It would have amended and extended beyond September 30 of last year, the Indian Health Care Improvement Act of 1976.

A principle justification for the veto, according to the President's veto message, revolved around an amendment which established a demonstration project within the state of Montana. This provision would have prohibited the Indian Health Service from considering an indigent Indian's eligibility for state and local health care programs funded by property taxes. In other words, with passage of this amendment, federal responsibility for Indian Health Care would be insured with no burden imposed on local non-tribal property owners.

Sponsored by Senator John Melcher (D-Mont.) ranking minority member of the Senate Select Committee on Indian Affairs, the provision came about as a result of contentions from Montana county welfare officials that Indians who did not pay property taxes were receiving benefits from local tax-funded medical programs. They point out that the federally financed Indian Health Service, rather than the local health programs should be the primary provider of care to indigent Indians in their State.

Legal precedence shows that dating from Cherokee Nation vs. Georgia, 30 US (5 Pet.) 1 (1831), the Federal Judiciary has recognized a federal trust reponsibility to Indians. Also, in at least two cases, Federal Courts have found federal trust responsibilities as a basis for requiring Indian Health Service to provide health service to Indian persons.

The admission of a federal obligation to Indian Health cost has been ordered in numerous court cases over the years. Until budgeting constraints became paramount, the Indian Health Service paid all costs in Montana, ignoring laws which had been on the books since 1920 allowing them to charge local governments for Indian health care. Only in recent years have Montana local government entities been expected to pick up the tab for Indian health care.

Indian Health Care has had a long-standing policy which has been disputed in courts, known as the "residual resource rule" in which the Agency pays for care in non-IHS facilities with "contact care" funds only after all third-party sources of payment have been exhausted.

The Indian Health Service "Alternate Resource Rule" is contrary to Federal Statutes and Congressional intent. The Snyder Act and the Indian Health Care Improvement Act were intended by Congress and have been construed by Federal Courts to entitle Indian persons to contract health care provided by Indian Health Service. Additionally the Johnson-O'Malley Act 25 USC 452 indicates Congress's intent that Indian Health Service be the primary resource and provider of health care for Indian persons.

Defenders of the Administration's position counter these points first by indicating that the cost would be too great and secondly by arguing that Montana Indians as

Montana citizens have a right to maintain their eligibility for State and local programs.

The issue of discrimination against counties who consider Indian Health Service the "primary resource" is invalid. The policy of determining persons eligible for benefits is based on the financial ability and resources of those persons. The policy of the county is not based on race. Rather the County has taken the position that because persons are eligible for Indian Health Service Medical care they are not in need and do not qualify for county medical assistance. No distinction is made between persons who may qualify for Indian Health Service Care, Medicaid, Medicare, or have private insurance. Such a classification based upon financial resources is certainly not invidiously discriminatory.

Several Montana tribes back the Montana demonstration program and support its inclusion in an Indian Health care bill. They feel that Indian health care is an entitlement based on treaty law and that the federal government should therefore be designed the primary provider of care for Montana Indians.

At our Montana meeting some of the directors made the following observations: 1). If Indian Health Service is not considered responsible for all Indians' health, why is there no means test conducted by that agency; 2). If there is no means test, then are all Indians going to be asked to come to the local department for a determination of eligibility; 3). Currently, if they come, the paper work required by local agencies is more than they can adequately handle; 4). Coming to the welfare office for an Indian is not socially accepted by his or her peers. Associating Indian health care with the welfare office is offensive particularly since well-to-do Indians receive their benefits at the Indian office while the poor must go to the welfare office; 5). Indians consider the Indian Health Service to be the responsible agency for their health care; 6). Indian Health Service has been the primary provider for years but now that money is tight they are looking to county entities; 7). The BIA is responsible to provide General Assistance to all registered Indians and General Assistance means providing the basic needs of life which includes medical needs.

Montana Roosevelt and Hill Counties have entire Indian Reservations within their borders. With the reservation being tax-exempt lands these counties have limited tax base to raise the mills needed to finance the local welfare programs. Also the state limits the number of mills a county may levy to fund their welfare programs.

Senator Melcher has re-introduced the Indian Health Care Amendments S.B. 277, deleting the Montana demonstration proposal. Nevertheless, the Montana County Directors continue to support the premise that the Indian Health Service should be the primary health resource for indigent Indians.

Senator ANDREWS. Let me, Doctor, ask if you would be so good as to accept that letter as a request to develop the question even more thoroughly at a later time.

Dr. GRAHAM. Also, at this point in the record, if we could, I would like to insert a copy of a resolution that we received this week from an official of the Rocky Boy's Reservation opposing this provision.

Senator ANDREWS. That is fine, so if you will take this letter from our Benson County people and respond to it, we will insert the Rocky Boy letter in the record and make a more complete record.[1]

Dr. GRAHAM. Yes.

[The response to issue in letter from Mr. Stanley Franek follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES—RESPONSE TO ISSUE IN LETTER FROM MR. STANLEY FRANEK

Mr. Stanley R. Franek, Director of the Benson County, North Dakota Board of Social Services, has written in support of a position paper of the Montana County Welfare Directors Association. The position paper presents the case for the premise that "the Indian Health Service should be the primary health resource for indigent Indians."

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[1] See appendix, p. 502, for Rocky Boy's Reservation resolution.

The Indian Health Service (IHS) programs are not needs based programs, i.e. eligibility is not based of any determination of an applicant's economic situation. The same rules apply to both indigents and non-indigents. IHS programs are not entitlement programs. Therefore, non-IHS providers of services must first look to programs for which the individual Indian patient is entitled before looking to IHS. These other programs include Federal, State, local and private, i.e. insurance, programs for which the individual Indian patient is eligible either because of meeting the specific program eligibility requirements or by meeting the terms of a contract.

For the IHS to pay for care provided by non-IHS providers where the individual Indian patient is entitled to have payment made by other programs would not only result in a reduction in the total health resources from all sources available to the Indian community and a negation of the individual's rights under other laws and contracts but could be viewed as a failure of the IHS to properly manage its limited funds in such a way as to maximize their impact on the health status of the Indian people.

Senator ANDREWS. In your prepared statement, Doctor, you opposed the designation of the Trenton service area as a contract health service delivery area so that services may be provided to members of the Turtle Mountain Band of Chippewa Indians. Now you say the provision would include the entire States of Montana and North Dakota, yet the language in the bill specifically alludes to only those counties of Divide, McKenzie, and Williams in North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

It is my understanding that funds have been appropriated in the past for the provision of services to these people, and that the Indian Health Service has provided services to them at the direction of the Senate Appropriations Committee.

Why do you object to formalizing what has been your practice in the past?

Dr. GRAHAM. I would like to have Dr. Rhoades respond to that question.

Dr. RHOADES. In general, Mr. Andrews, we would feel that legislation should not be required to deal with that problem. We have been engaged in discussions, both with the Aberdeen area and with the Billings area, to find ways to more appropriately provide care to the residents of the Trenton-Williston area and believe that we will be able to arrive at a solution that should be satisfactory.

Senator ANDREWS. Well, we appreciate that, but again, your field officials change from time to time. Policies change from time to time. In essence, what we are doing is trying to put into legislation the assurance that there will be a continuity of program effort to help you continue to do, or your successors continue to do, what you have started out to do. We are just trying to help you out.

Dr. GRAHAM. We always appreciate assistance from whatever quarter.

Senator ANDREWS. I am sure you appreciate that.

Dr. GRAHAM. The difference that we have, though, is that as a matter of principle, we do object to statutory direction on administrative provisions. Now, you said from time to time officials change and policies change. Also, sir, from time to time needs change and demands change. I think it is important that there be appropriate oversight and accountability between us and the Congress in terms of our stewardship of the program, but we cannot have a circumstance where there are specific directions in statute which say you must administer this way for this tribe and that way for another tribe.

There are some 400 or so recognized tribes. I do not believe that the statutory process can make adequate provision for individual consideration of each tribe and each particular need.

Senator **Andrews**. Doctor, given your opposition to the proposal to elevate the Indian Health Service to the agency level within the Public Health Service, can you tell us what specific functions the Health Resources and Services Administration performs for the Indian Health Service?

Dr. **Graham**. We provide, I guess what I would describe as two separate types of functions, sir. One is a type of administrative infrastructure serving as an interface between the four bureaus in the Agency and the Office of the Assistant Secretary. This includes such things as working with the IHS on planning, evaluation, legislative issues, and budgetary issues. Our personnel shop staffs the Indian Health Service in the Parklawn Building.

The other type of function that we provide, since we are the Health Resources and Services Agency and our other bureaus are directly responsible for the delivery of services, is that we try to create an environment whereby we can make it possible for the Indian Health Service to have access to the maximum level of services or resources that can be applied to the care of Indian people. There are considerable amounts of conversation that go on between the Indian Health Service, the National Health Service Corps, and other elements of the agency.

If you would like a specific breakout of the types of functions and numbers of people assigned, we would be happy to do that for the record, but that is just to give you some sense of how things work in an agency and with a bureau.

Senator **Andrews**. Thank you, Doctor, but doesn't HRSA perform contracting functions for the IHS?

Dr. **Graham**. Yes, we do have a contracting office that is part of the procurement operation.

Senator **Andrews**. Over the course of this committee's eight hearings on the reauthorization bill in the 98th Congress, we repeatedly heard scores of examples of the problems that tribes are confronting in contracting with the Department. They are having trouble in the procurement of emergency equipement. It can take up to 18 months.

Contract care providers are not paid on a timely basis. They often proceed to try to secure collection from the individual Indian patient. The patient, of course, is not liable for that bill. The Indian Health Service is, but it is the patient's credit record that is damaged in these instances.

The self-determination contracts, for instance, in the area of contracting for the planning and design of IHS facilities is delayed for years, often with no justification given to the tribes. Rosebud, which you mentioned the other day, is an example of this.

I have to wonder out loud why. How good a job are you doing in helping out the Indian Health Service in the area of contracting?

Dr. **Graham**. I think it has been my experience that procurement and personnel in Federal agencies are always among the most sensitive of issues between the program and the administrative side. Since my tenure at this agency, Dr. Rhoades and I have specifically discussed on numerous occasions both procurement policy and specific procurement activities that could be taken to assist the Indian Health Service. Some of those activities that you went through are responsibilities of my staff in the Parklawn Building. Some of you cite, such as the decision about the availability of contract services and payment for those services, have to do more with the IHS area office and area office staff.

What we must do is strike a responsible balance between the needs of the individual program officials, the patients which they are serving, and the procurement laws which are passed by the Congress and which we are expected to observe in terms of fairness in bidding and lowest price available. Sometimes it takes a certain amount of negotiation with our program staff to make sure that we are not running a mom-and-pop shop and just taking care of our friends and are totally ignoring the procurement statutes.

So, there is a body of law which dictates how Federal money is to be expended, and the procurement shop is responsible to carry that out. There is always a degree of creative tension within that. What Dr. Rhoades and I do to the best of our ability is to make sure that we are following the law and the procedures as expeditiously as possible.

Senator ANDREWS. Doctor, your statement also indicates that it is your position the Indian Health Service has sufficient access to the leadership of the Department and, thus, the elevation of the Indian Health Service is not warranted. If that is true, why is it that after many repeated requests over a 9-month period, the Department was unable to produce a legislative report to the Congress on either the House or the Senate bills that proposed to reauthorize the Indian Health Care Improvement Act in the 98th Congress?

Dr. GRAHAM. There are certainly a number of issues that are attendant to the preparation and clearance of that report, none of which seem to have much to do with the location of the Indian Health Service within the Department. Reports are a matter of policy. Policy is reviewed and cleared, as you are well aware, by individuals within the Department and the Office of Management and Budget to make sure that the communication that we are giving to the Congress is as clear an explication of the President's policies and priorities as possible. There were and are a number of sets of negotiations which have to go on any time we prepare a report and submit it for clearance for eventual submission to the Congress.

What happened with that particular report is that we got caught up in a number of policy questions, some of which we have debated with you in the reauthorization hearings and the budget hearings last year, that delayed the report submission beyond what I would consider to be timely.

Senator ANDREWS. Doctor, finally, I note once again your opposition to the continuation of the Community Health Representative Program and the urban Indian health programs. I myself have been out in Seattle seeing what the urban Indian health programs can do. We also have an excellent program in Minneapolis and St.

Paul, as you know. The fiscal year 1986 budget request, as you know, once again proposes no funding for these programs.

It bothers me, Doctor, because I thought that the major thrust of what we are trying to do is to encourage those Indians who wanted to become self-sufficient off the reservation. Granted this health care delivery system is somewhat of a halfway house, but if you do not have it, it is another slap in the face and a move to drive them back to the already overcrowded reservations where there simply are not job opportunities. The highest unemployment exists on, in, and around the Indian reservations in this country of ours. I think it is a legitimate purpose of any administration to try to encourage our Indian people who wish to, to move away to find job opportunities if they are comfortable in doing that.

Now, it bothers me, of course, that your budget request once again proposes no funding for these programs, as I said. In my judgment, the Department has not been able to produce one cost-effective reason for eliminating these critical and important programs. Obviously, they cost money, but it costs much more to maintain that tribal member back on the reservation where there are not any jobs. If you do not care about the people and what they want to do, and if you are just concerned about the almightly dollar, then you must consider that for every dollar you shortchange this program, you are going to have to pay $4 in providing health care to the unemployed individual back on the reservation.

Unless you can come up with some justification for this kind of a cut, dollars and cents-wise, and in terms of effectiveness from the standpoint of the human needs of these individuals, I think that we are going to have to push ahead and establish these programs as permanent programs of the Indian Health Service.

Do you have any comment on that, Doctor? Am I off on some wild tangent? These are observations that I have made from the time I have spent out in the field. You have spent much more time in this than I have, Doctor.

Dr. **Graham**. I would not characterize your comments as wild observations. As we have discussed before in the budget oversight and in the review of the President's request in prior years, there are two different rationales which underlie those budget requests. The basic principle is the fact that we have found it necessary in a period of restricted Federal resources to make some decisions about choices and priorities. As we have talked about before in the area of community health representatives, we would never say to you that we find that program to be not effective or not accomplishing some good. It is simply that it has been our judgment, within the resources available, that the highest priority must go to the clinical care of individuals on or near reservations.

In the case of the urban health programs, we do feel that there is an additional argument which can be made, and that is that individuals who may choose to relocate to urban areas also are moving to areas where there are other Federal and additional public programs which seek to provide care to individuals who may not otherwise be able to find it. We have a system of some 600 federally funded community health centers, some 2500 National Health Service Corps assignees, many of which are in urban areas. There are city and county programs that provide services. So, an individual who does happen to relocate to an urban area is in a position where he or she may have access to a variety of set of services that would not be available on the reservation.

Senator **Andrews**. Thank you very much, Doctor.

Senator Melcher.

Senator **Melcher**. Dr. Graham, I know you have already responded once to a similar question, but the budget you are recommending is about what, $750 million?

Dr. **Graham**. Yes; depending on what categories. That is certainly in the ballpark, yes, sir.

Senator **Melcher**. And just to get back to the basics, is this, in your judgment, a Federal responsibility?

Dr. **Graham**. Is the care of Indian individuals a Federal responsibility? I feel that there are some clear responsibilities of the Federal Government which evolve from treaty obligations which we are seeking to carry out through this budget.

Senator **Melcher**. Based on treaty law, then?

Dr. **Graham**. Yes.

Senator **Melcher**. Plus acts of Congress?

Dr. **Graham**. Yes.

Senator **Melcher**. Is that yes?

Dr. **Graham**. Sorry, that is an affirmative.

Senator **Melcher**. Then, based on that treaty law and the acts of Congress, what is in the law that allows you to disregard that responsibility for indigent Indians that are from a reservation and enrolled in the Indian tribe?

Dr. **Graham**. Disregard in what way, sir?

Senator **Melcher**. Well, recommending the veto of this simple language. It says that eligibility of any Indian for medical or health assistance that is provided to indigents by the State or local government shall not be taken into account in determining the eligibility of such Indian for medical or health services provided for or on behalf of the Indian Health Service if medical and health assistance by a State or local government is funded by the revenues from any tax imposed on real property and such Indian resides on a reservation or restricted Indian land which is not subject to taxation.

We did not used to have to put that kind of language in a bill. We found we have to now. On what basis do you justify three-quarters of a billion dollars in spending out of the Treasury for Indian health and then denying health care when the Indian happens to be indigent?

Dr. **Graham**. I believe the point around which we are disagreeing and the specific provision that was in the proposed bill last year was that it, in our view, inappropriately denied to Indian individuals rights which are theirs as members of a State or county.

Senator **Melcher**. That is not the law. We are not talking about what you view. We are talking about how the law applies. If the treaties and the acts of Congress apply to paying for that Federal responsibility for Indian health, how can it deviate for indigents?

Dr. **Graham**. I do not believe the distinction that we are making is around the status of medical indigency. I believe the distinction where you and I may differ, as discussed with the chairman prior to the time that you were here, in my view and I believe in the view of the President, is that Indian individuals are citizens of the States in which they reside.

Senator **Melcher**. That is another part of the law. I am just talking about the law on which you base the three-quarters of a billion dollars for paying for Indian health. You said that it is based on treaties and acts of Congress and that it is a Federal responsibility. Is that right?

Dr. **Graham**. You are following a line of reasoning, sir, which would say that it is solely Federal responsibility.

Senator **Melcher**. Whose responsibility is it first? Let's just stick to that. Forget about solely.

Dr. **Graham**. Since those treaty obligations are in effect only as Congress may from time to time provide an appropriation, and since the Congress may decide not to provide an appropriation, I must assume that the basic obligation for whatever services are to be provided citizens resides with the States and the local communities since these Indians are still citizens.

Senator **Melcher**. Are you saying you are out of money?

Dr. **Graham**. No.

Senator **Melcher**. Then it would not apply, would it? You said Congress appropriated. Now, we have appropriated funds. Are you out of money?

Dr. **Graham**. We are not out of money. Would you argue that $756 million in your view meets the total health needs of the Indian people?

Senator **Melcher**. I am not trying to get into what you do or do not do in meeting all of the responsibilities. I am asking a basic question. It is very simple. Under what Federal law do you exempt indigent Indians from a Federal responsibility for their health care?

Dr. **Graham**. There is a body of court decisions, which I would be happy to provide for you at this point in the record, which are based on a variety of citations of Federal statute—I do not have those committed to memory—which have laid down the basic premise that services provided by the Indian Health Service on appropriation from the Congress are residual to services available to the Indian individuals from other sources. There is a body of law and court finding which supports that view, and I will submit such at this point in the record.

Senator **Andrews**. That will be made a part of the record at this point.

[Legal brief for the Federal Government containing points and authorities in defense of the plaintiff's action follows. Testimony resumes on p. 130.]

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
GREAT FALLS DIVISION

PAMELA KELLER MCNABB
as Guardian *Ad Litem*,
for James McNabb, a minor person,

Plaintiff

vs.

MARGARET HECKLER, et al.,

Defendants,
and,

J.T. BROWNLEE, et al.,

Defendants.

CIV. NO. 83-51-GF

MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF FEDERAL DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

PRELIMINARY STATEMENT

This lawsuit is brought by the non-Indian mother of an Indian child for payment of the child's hospital and medical bills. The child, James McNabb, is an Indian eligible for health services from the Indian Health Service (IHS). James also meets the eligibility criteria for county medical assistance administered by Roosevelt County under Montana's general relief laws. Roosevelt County will not pay James' bills because the county contends that the IHS should be the primary payor. The IHS has not paid James' bills because the IHS contends that Roosevelt County should be the primary payor. Thus, both programs claim residual status.

Plaintiff has sued both the Federal and County defendants alleging that both the Federal and the County defendants are responsible for payment of James' bills. The Federal and County defendants have cross-claimed against each other asserting that their respective programs are residual. Since both the IHS and the County programs have denied payment on the sole ground that the other program is responsible, and James' eligibility for benefits under both programs is not otherwise at issue, the only issue for resolution by the Court is which program is the primary payor responsible for James' bills. Federal defendants bring this motion for summary judgment to resolve that issue.

STATEMENT OF FACTS

James McNabb is the Indian child of Pamela Keller McNabb and Raymond McNabb. Pamela is non-Indian and Raymond is a Chippewa-Cree Indian. At all times relevant to this lawsuit, during Pamela's pregnancy with James through the present time, Pamela, Raymond and James have resided in Wolf Point, Montana, on the Fort Peck Indian Reservation in Roosevelt County.

On November 30, 1981, Pamela who was seven months pregnant with James, was admitted to the Trinity Hospital in Wolf Point, Montana, by Dr. Martha Coyner, a non-IHS physician. Shortly thereafter, on December 4, 1981, Pamela was transferred to Mercy Hospital in Williston, North Dakota. James was born on December 4, 1981, at Mercy Hospital. He was eight weeks premature.

Five hours after his birth James was flown to St. Vincent's Hospital in Billings, Montana. James remained at St. Vincent's until January 17, 1982, when he was transferred to Trinity Hospital in Wolf Point. James was discharged from Trinity Hospital two days later.

On January 8, 1982, Pamela applied to the Roosevelt County Department of Public Welfare for county medical assistance. See Montana Statutes §53-3-103. [*] Pamela's application for payment of the hospital and medical bills for herself and James was denied by the county on February 11, 1982 for the stated reason that "James and your needs should be covered by Public Health Service." (See letter from Kali Lien, Eligibility Technician, to Pamela McNabb dated February 11, 1982 -- Appendix F to plaintiff's complaint).

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[*] Section 53-3-103(1) mandates that "medical aid and hospitalization for county residents and nonresidents within the county unable to provide these necessities for themselves are the legal and financial responsibility of the county commissioners and are payable from the county poor fund." The county medical assistance program is to be distinguished from the Federally-supported, but State-operated Medicaid program.

Roosevelt County has subsequently paid the medical and hospital bills for services to Pamela related to James' birth. County defendants still refuse to pay James' bills based on their contention that IHS is responsible for payment.

Pamela has appealed the county's refusal to pay James's bills through the state administrative appeals process. The hearings officer for the State Department of Social and Rehabilitation Services decided in January 1983 that Roosevelt County was responsible for payment. (Copy of decision attached as Exhibit A.) The State Board of Social and Rehabilitation Appeals affirmed the hearing officer's decision in March, 1983. (Copy of affirmance attached as Exhibit B.) The hearing officer made specific findings that the IHS contract care program was residual to Roosevelt County's Medical Assistance program and that IHS was not an entitlement program. The hearing officer held that Roosevelt County's actions in avoiding responsibility for payment of

James' bills "under the guise of Indian Health Services is unlawful and unfair." The hearing officer's decision and its affirmance constitute final state agency action.

Roosevelt County is operating its county medical assistance program under a plan which has not received the approval of the Montana Department of Social and Rehabilitation Services. An approved plan is required by A.R.M. 46.9.407 */, which provides in pertinent part, as follows:

> 46.9.407 COUNTY PLAN (1) Counties shall write their own general assistance and medical rules which then must be approved by the department [DSRS] to be effective prior to implementation.
>
> * * *
>
> (b) For county medical assistance, any county whose plan or portion thereof that has not been approved must use the maximum income and resource assets criteria of the medicaid program for eligibility determination and applicable criteria for furnishing assistance, except that medical assistance may not be provided to individuals whose income exceeds 300% of the AFDC standard.
>
> * * *

County defendants admitted in answers to interrogatories which Federal defendants served on them last December that they do not have a State approved county medical assistance plan under A.R.M. 46.9.407(1), and stated expressly that they were operating under a policy which had been disapproved by the State. (See County defendants' Answers to Interrogatories, 1(c) and 1(f)(ii), attached as Exhibit C.) They further admitted that Roosevelt County was not in compliance with A.R.M. 46.9.407(1)(b) which requires a county without an approved plan, such as Roosevelt County, to use the State's Medicaid eligibility rules for determining eligibility for county medical assistance. (See Exhibit C, 1(h).) Under the Medicaid eligibility rules, it is impermissible to rely on IHS as a prior resource (see McCabe deposition at Exhibit D at 14).

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*/ This section was renumbered as A.R.M. 46.25.302 on July 1, 1983. However, it will be referred to as A.R.M. 46.9.407 in this brief because that was the correct citation at the time the events in this action occurred.

In a deposition conducted by the Federal defendants on February 1, 1984, Mr. James (Jimmy) McCabe, Chief of the Eligibility Policy Bureau, Economic Assistance Division, DSRS, pointed out that his office, which is responsible for approving Montana county medical assistance plans, does not approve county plans which contain provisions stating that a county could rely on IHS as a prior resource. (See McCabe deposition at Exhibit D at pp. 14-15.) He produced documents indicating that portions of county plans had been disapproved by his office for containing such prohibited provisions. (See Exhibit E, pages 1-4.) Mr. McCabe stated that Roosevelt County did not have an approved plan in 1982 and still does not have one. (See McCabe deposition at page 10.)

Mr. McCabe explained that Montana used to have an administrative rule which provided that IHS could be relied on by counties as a prior resource in making eligibility determinations. That rule, A.R.M. 46.9.509, was repealed on July 9, 1982 (see Exhibit F), because of DSRS legal opinions to the effect that the rule conflicted with the Federal IHS residual resource rule and was therefore invalid. (See Exhibits G and H.)

In spite of the repeal of this rule Roosevelt County has admitted in documents filed with this Court (See Preliminary Pretrial Memorandum of County Defendants at page 2.) and in its answers to Federal defendants' interrogatories that it relied on this rule which was declared invalid as early as March, 1982, by DSRS attorneys, and which was officially repealed in July 1982. The following answers by County defendants' to interrogatories 2(a)-(c) (see Exhibit C) show that the County relied on the provisions of the repealed rule when it reconsidered its decisions with regard to the payment of Pamela's and James' bills:

> Question:
> (a) Did Roosevelt County reconsider its initial decision and on or about September 14, 1982, agree to pay for Pamela McNabb's medical bills, but not for James'?
>
> Answer:
> Yes, reconsidered on 11/15/82

> Question:
> (b) Explain in detail the reason or reasons why Roosevelt County decided to pay Pamela McNabb's medical bills and produce any documents related to the reconsideration decision (including, but not limited to copies of minutes of meetings or notes taken during the reconsideration process, any copies of correspondence or other documents discussing the decision with regard to Pamela McNabb, etc.).
>
> Answer:
> Roosevelt County made a verbal agreement with Legal Aid Attorney, Sarah Arnott, who stated that if we agreed to pay Pamela McNabb's (non-Indian) medical bills she would get IHS to pay James McNabb's (Indian) medical bills.
>
> Question:
> (c) Was Roosevelt County's continuing decision, after the reconsideration process described above, not to pay for James McNabb's medical bills based upon its reliance on A.R.M. 46.9.509(1)(b)?
>
> Answer:
> Yes

In its Answer and Cross-Claim filed with this Court on May 31, 1983, the County defendants expressly stated that "never has the County provided medical assistance to Indian persons, whether indigent or otherwise..." This statement is supported by County defendants' response to Federal defendants' interrogatory 7, which asked how many individuals receiving Roosevelt County medical assistance in calendar years 1982 and 1983 had been Indians. The County's response was "none". (See Exhibit C.)

Pamela also requested IHS to authorize payment of James's bills under the IHS contract health services program. 42 CFR §36.21 et seq. The IHS has refused to authorize payment on the ground that Roosevelt County's medical assistance program is an alternate resource responsible for payment. The IHS denial has been affirmed on appeal through the IHS appeals process (42 CFR §36.25) and constitutes final agency action. See letter dated November 11, 1982 from Everett R. Rhoades, M.D., Director of the Indian Health Service to Ms. Sarah Arnott, plaintiff's attorney, advising her of IHS' denial of payment and the reasons therefor. (Copy attached as Exhibit I.)

The IHS denial of payment is based on the following Federal regulation at 42 CFR §36.23(f):

> "(f) Alternate resources. Contract health services will not be authorized by the Indian Health Service when, and to the extent that, alternate resources for the provision of necessary medical services are available and accessible to the individual requesting the services, or would be available and accessible upon application of the individual to the alternate resource.

Federal regulations define "alternate resources" at 42 CFR §36.21(a) as meaning:

> "resources other than those of the Indian Health Service contract health services program, available and accessible to the individual, such as health care providers

> and institutions (including facilities operated by the Indian Health Service), health care payment sources, or other health care programs for the provision of health services (e.g., medicare or medicaid) for which the individual may be eligible."

While, as plaintiff asserts, IHS did at one point in a letter to plaintiff's attorney declare James to be technically "eligible" for contract health services because there was at that point documented evidence (acknowledgement of paternity) that he was Indian, the IHS stated in that same letter that authorization of payment for James' bills would not be made until Roosevelt County had made a final decision on whether it was responsible for payment. The letter stated that IHS "would consider Roosevelt County as being primarily responsible..." (Letter dated August 27, 1982 from J.R. Smith, Director, IHS Billings Area, to Sarah Arnott. Copy attached as Exhibit J.). A month later J.R. Smith wrote to Ms. Arnott again pointing out that Roosevelt County had denied payment for James' bills and that the County's reason was that it had decided that IHS was responsible. Mr. Smith advised Ms. Arnott that the IHS disagreed with the County's determination and felt that the County was primarily responsible for payment. In other words, Mr. Smith was saying that there was an "alternate resource" for the payment of James' bills. (Copy of September 27, 1982 letter from J.R. Smith to Sarah Arnott attached as Exhibit K.) Finally, in response to Ms. Arnott's appeal of the Area Director's finding, Dr. Everett Rhoades, Director of IHS, in a letter dated November 11, 1982 (Exhibit I), advised Ms. Arnott that he was affirming Mr. J.R. Smith's denial determination and that "the reason for the denial was that an alternate resource was available, namely County Medical Assistance from Roosevelt County, Montana." */

ARGUMENT

A. Summary

This case involves a challenge to the Indian Health Service's "alternate resource rule" at 42 CFR §36.23(f), on its face and as applied to the particular facts here, which provides that the Indian Health Service will pay for health

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*/ Although the only issue before the Court is the denial of payment for James' bills, it should be noted as background information that payment for Pamela'a bills was denied by IHS because she did not make a reasonable effort, prior to her delivery, to determine her eligibility status with IHS or to utilize IHS doctors and facilities. Instead she chose to use a non-IHS doctor. Then after her delivery she came to IHS to ask that her medical bills be paid. However, she never showed proof of marriage to an Indian nor did she have an affidavit of common law marriage to an Indian, which was required because Pamela was non-Indian, even though she was advised by IHS that those were the rules. In any event, Roosevelt County paid Pamela's medical bills.

services rendered in non-IHS facilities (contract care) only after all other third party sources of payment have been exhausted. Roosevelt County has for over a year refused to pay for James' treatment, completely ignoring two Montana Department of Social and Rehabilitation Services (DSRS) decisions holding that the County is responsible for payment. The County is also ignoring a decision of the Supreme Court of Montana in *County of Blaine* v. *Moore*, 568 P.2d 1216, 1222 (1977), holding that county medical assistance must be provided when there is regulatory justification for denial of IHS contract care. Ignoring their obligations under State law, County defendants claim that their program is residual to the IHS despite a Federal regulation to the contrary.

While the facts of this case may make it appear to be a simple squabble over the payment of one child's hospital bill, the case has broad implications for the IHS program nationwide and for the rights of Indians to receive equal treatment under State law. Should Roosevelt County be permitted to pass off its clear legal obligation under State law to the IHS, there is a real danger that other jurisdictions would follow suit. Nationally, the implications for the IHS are enormous. The IHS is hard pressed to meet even the minimal health needs of the Indian population it serves. Furthermore, to condone the County's actions would repudiate a long line of court decisions holding that Indians are entitled to State benefits on an equal basis with other citizens.

The Federal defendants will show that the IHS contract care program is not, as the County defendants assert, an entitlement program for Indians upon which the County may rely as a reason for denying county medical assistance to its Indian residents. Federal defendants will show that the IHS alternate resource rule at 42 CFR § 36.23(f) is a valid regulation promulgated within the scope of the Secretary's authority. We will show that on the facts of this case, the IHS determination that Roosevelt County is an alternate resource for payment of James' hospital and medical bills is rational and proper. We will further show (1) that County defendants' refusal to provide medical assistance to James violates Montana law, (2) that County defendants' policy is invalid under the Supremacy Clause, and (3) that County defendants' continued refusal to pay James' bills under these circumstances violates James' right to Equal Protection under the Fourteenth Amendment.

B. Standard of Review Applicable to the Secretary's Determination is Whether the Decision was Arbitrary, Capricious, or Otherwise not in Accordance with law

While the IHS decision to deny payment for James' medical bills based on the determination that Roosevelt County was an alternate resource is reviewable under section 706 of the Administrative Procedure Act (5 U.S.C. 706), the applicable standard of review is whether the IHS decision was "arbitrary, capricious, or otherwise not in accordance with law." See 5 U.S.C. 706(2)(A). Courts reviewing an agency action, such as the instant one, are to "consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 416 (1971). However, as the Overton Park case further holds, a reviewing court is not empowered under this narrow standard of review to substitute its judgment for that of the agency. The standard of review is a very deferential one. There is a presumption that the agency's action is valid. If the agency's decision was based on relevant factors and has a rational basis, it must be upheld. See Ethyl Corporation v. Environmental Protection Agency, 541 F.2d 1, 34 (D.C. Cir. 1976), cert. denied 426 U.S. 941 (1976).

C. The IHS alternate resource rule is a valid regulation.

1. Promulgation of the alternate resource regulation is within the Secretary's authority in administering a Snyder Act program.

The underlying statutory authority for the IHS program is the Snyder Act, 25 U.S.C. 13. The Act states in pertinent part:

> The Bureau of Indian Affairs, under the supervision of the Secretary of the Interior, shall direct supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States for the following purposes:

* * * *

> For relief of distress and conservation of health.

* * * *

> For the employment of inspectors, supervisors, superintendents, clerks, field matrons, farmers, physicians, Indian police, Indian judges, and other employees. (Emphasis added).

This authority, with respect to Indian health, was transferred to the Secretary of Health and Human Services in 1955 pursuant to Pub. L. 85-568, 42 U.SC. 2001 et seq.), which states in pertinent part:

> All functions, responsibilities, authorities, and duties of the Department of the Interior, the Bureau of Indian Affairs, Secretary of the Interior, and the Commissioner of Indian Affairs relating to the maintenance and operation of hospital and health facilities for Indians, and the conservation of the health of Indians, are transferred to, and shall be administered by, the Surgeon General of the United States Public Health Service, under the supervision of the Secretary of Health, Education, and Welfare. [42 U.S.C. 2001] */

* * * *

The Secretary of Health, Education and Welfare is also authorized to make such other regulations as he deems necessary to carry out the provisions of this chapter. [42 U.S.C. 2003]

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*/ By section 1 of Reorganization Plan No. 3 of 1966, 5 U.S.C. App., "all functions of the Surgeon General of the Public Health Service" were transferred to the Secretary of Health, Education and Welfare. The Secretary's title has been changed to the Secretary of Health and Human Services. See 45 Federal Register 29642-3 (May 5, 1980) for change of name.

As noted by the Supreme Court in Morton v. Ruiz, 415 U.S. 199 (1974), to be discussed infra., "The Snyder Act . . . does not provide eligibility requirements or the details of any program." 415 U.S. at 208. Its purpose is stated succinctly by the Court:

> The Snyder Act, 42 Stat. 208, 25 U.S.C. 13, approved November 2, 1921, provides the underlying congressional authority for most BIA activities. . . Prior to the Act, there was no such general authorization. As a result, appropriations requests made by the House Committee on Indian Affairs were frequently stricken on the House floor by point-of-order objections. . . The Snyder Act was designed to remedy this situation. It is comprehensively worded for the apparent purpose of avoiding these point-of-order motions to strike. Since the passage of the Act, the BIA has presented its budget requests without further interruption of that kind and Congress has enacted appropriation bills in response to the requests. 415 U.S. at 206-207.

There is nothing in the Snyder Act making the provision of health services for Indians an exclusive federal responsibility. Indeed, Indians are citizens of the United States and of the state in which they reside (8 U.S.C. §1401(b)). Traditionally they have been afforded both the privilege of tribal membership and of state citizenship, and these rights have long been held not to be incompatible. United States v. Nice, 241 U.S. 591 (1916); Board of Commissioners v. Seber, 318 U.S. 705 (1943). Indians are entitled to Social Security Act benefits on an equal basis with other citizens, Ruiz, supra., 415 U.S. at 208, nt. 11, and are protected under federal civil rights legislation against discrimination in the administration of programs which receive federal funds. Furthermore, as state citizens, Indians are constitutionally entitled under the Equal Protection Clause of the Fourteenth Amendment to state privileges and services provided to other state citizens: medical care, State ex rel Williams v. Kamp, 78 P. 2d 585 (Mont. 1938), Acosta v. San Diego County, 272 P. 2d 92 (Calif. 1954); voting rights, Little Thunder v. South Dakota, 518 F. 2d 1253 (8th Cir. 1975), United States v. Apache County, Arizona, 429 U.S. 876 (1976), aff'g mem. Civil No. 74-50 (D. Ariz. 1975); the right to a state supported education, Prince v. Board of Education, 543 P. 2d 1176 (N.M. 1975).

The Ruiz decision made it very clear that the federal agency administering a Snyder Act program has the power to define eligibility requirements and limit program benefits in accordance with rational standards.

> Having found that the congressional appropriation was intended to cover welfare services at least to those Indians residing 'on or near' the reservation, it does not necessarily follow that the Secretary is without power to create reasonable classifications and eligibility requirements in order to allocate the limited funds available to him for this purpose. (Citations omitted). Thus, if there were only enough funds appropriated to provide meaningfully for 10,000 needy Indian beneficiaries and the entire class of eligible beneficiaries numbered 20,000, it would be incumbent upon the BIA to develop an eligibility standard to deal with the problem; and the standard, if rational and proper, might leave some of the class otherwise encompassed by the appropriation without benefits. But in such a case the agency

> must, at a minimum, let the standard be generally known so as to assure that it is being applied consistently and so as to avoid both the reality and the appearance of arbitrary denial of benefits to potential beneficiaries. (415 U.S. at 231-32). (Emphasis added).

We note that the Court in Ruiz struck down the BIA policy limiting BIA general assistance benefits to Indians residing on reservations because the policy was not promulgated in accordance with rulemaking procedures required by the Administrative Procedure Act, 5 U.S.C. 553. The Court observed:

> Assuming, arguendo, that the Secretary rationally could limit the "on or near" appropriation to include only the smaller class of Indians who lived directly "on" the reservation plus those in Alaska and Oklahoma, the question that remains is whether this has been validly accomplished. The power of an administrative agency to administer a congressionally created and funded program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress. 415 U.S. 232.

After discussing the requirements of the Administrative Procedure Act (APA), 5 U.S.C. 551 et seq., the Court concluded that:

> The conscious choice of the Secretary not to treat this extremely significant eligibility requirement, affecting rights of needy Indians, as a legislative type rule, renders it ineffective so far as extinguishing the rights of those otherwise within the class of beneficiaries contemplated by Congress is concerned. (Emphasis added). 415 U.S. at 237.

The BIA, in Ruiz, had relied on an unpublished manual provision with the total absence of any regulatory base. In contrast, the IHS alternate resource rule is set out in federal regulations specifically governing authorization of IHS contract health services published on August 4, 1978 (42 CFR §36.23(f)), and has been in the federal regulations governing the Indian health program since 1956 (42 CFR 36.12(c)). The regulation is a legislative-type rule adopted under the Secretary's rulemaking authority at 42 U.S.C. 2003 (quoted above), and was promulgated in accordance with rulemaking procedures required by the Administrative Procedure Act, 5 U.S.C. §553. */

The alternate resource regulation at 42 CFR §36.23(f), at issue here, is precisely the kind of agency action which the court in Ruiz acknowledged is within the Secretary's authority in administering a Snyder Act program. The regulation is designed to assert and preserve the Indian's right, as a citizen, to other federal, state and county benefits by limiting the Indian's eligibility for IHS contract health

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*/ A notice of proposed rulemaking for contract health services was published on October 22, 1976 (41 Federal Register 46792 et seq.) and the final rule was published on August 4, 1978 (43 Federal Register 34650 et seq.) These documents are attached hereto as Exhibits L and M, respectively.

services. Thus, a state or county program may not presume that Indians have a right or entitlement to IHS contract health services which may be invoked to deny state or county assistance on the ground of double coverage. The federal regulation denies such a right.

The regulation is a reasonable means for allocating scarce contract health services resources. It accommodates the Indians' rights as state citizens with the need to conserve very limited IHS contract care funds for the benefit of the entire tribal service population. Even with this regulation, funding levels for IHS contract health services have caused the IHS to apply strict medical priorities under 42 CFR §36.23(e) such that contract health services generally have been restricted to payment for emergency services. */ See Declaration of Everett R. Rhoades, M.D., attached hereto as Exhibit N.

2. The federal trust responsibility to Indians does not preclude the IHS from adopting the alternate resource rule.

The *Ruiz* decision reconciles the power of the administering federal agency to limit Snyder Act program benefits (through adoption of reasonable eligibility and allocation criteria) with the trust responsibilities of the Federal Government toward Indians. The trust responsibility does not provide Indians with a legal entitlement to federal benefits precluding the agency from limiting benefits. However, the trust responsibility does require the agency to deal fairly with Indians, i.e., to limit benefits in accordance with established administrative procedures. */

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*/ Regulations on medical priorities at 42 CFR §36.23(e) state:
(e) Priorities for contract health services. When funds are insufficient to provide the volume of contract health services indicated as needed by the population residing in a contract health service delivery area, priorities for service shall be determined on the basis of relative medical need.

This view was followed by the Tenth Circuit in Vigil v. Andrus, 667 F.2d 931 (10th Cir. 1982) involving a BIA restriction on eligibility for free school lunches. The school lunch program for Indians was funded under the Snyder Act. The court determined that although the Federal Government had broad fiduciary obligations toward Indians, the Government is not obligated to provide particular services or benefits in the absence of a specific provision in a treaty, agreement, executive order or statute. The court held that neither the Snyder Act nor the Government's trust responsibility created

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*/ We note also that the Ninth Circuit has held that funds appropriated under the Snyder Act are "gratuitous appropriations of public monies" and not treaty or tribal funds "belonging really to the Indians." Scholder v. United States, 428 F. 2d 1123, 1129 (9th Cir. 1970), Cert. denied, 400 U.S. 942 (1970) IHS appropriations are not the equivalent of tribal assets or lands held in trust for the tribe by the Federal Government. Thus, cases such as Seminole Nation v. United States, 316 U.S. 286 (1942) holding that the United States must exercise the same fiduciary obligations as a private trustee toward trust property do not apply here.

a legal entitlement to free school lunches precluding the power of the BIA to limit benefits under the program.

There is nothing to the contrary in the court's discussion of the federal trust responsibility in White v. Califano, 437 F. Supp. 543 (D.S.D. 1977), aff'd 581 F. 2d 697 (8th Cir. 1978). In White, the IHS invoked the alternate resource rule in refusing to provide contract health benefits to a dangerously mentally ill Indian who resided on a reservation in South Dakota and was in need of involuntary commitment to institutionalized care. The IHS contended that the Indian had a right to care from the state and thus had an alternate resource to which the IHS was residual.

The court held that state officials had no jurisdiction to involuntarily commit Indians, who both reside on and are physically present on a reservation, to the state hospital. The court's holding that the state lacked jurisdiction to involuntarily commit the plaintiff to institutionalized care is based on a dual rationale: (1) state action would infringe upon "the right of reservation Indians to make their own laws and be ruled by them" (tribal sovereignty), and (2) state action is preempted by federal law requiring a disclaimer of jurisdiction over Indian country as a condition of statehood. (Enabling Act of Feb. 22, 1889, 25 stat. 676).

In the absence of this jurisdiction, the court held that the state had no obligation to provide the needed care. The court recognized that the Indian plaintiff was a citizen of South Dakota entitled to equal protection. 437 F. Supp. at 546. However, the court determined that "lack of jurisdiction precludes the [state] action demanded by plaintiff, the equal protection issue itself cannot be reached." 437 F. Supp. at 551. The court concluded that:

> The discretion of I.H.S. officials was based upon their assumption that Florence Red Dog had 'access to other arrangements for obtaining medical care.' The earlier part of this opinion has, of course, destroyed the assumption upon which agency action was based. Thus at this time, all this court will require is that the I.H.S. conform their policy to 42 C.F.R. §36.12(c); */ the standard set therein cannot be superseded or replaced by ad hoc internal policy - making decisions. (437 F. Supp. at 556).

Once the court had determined that the State of South Dakota was not an alternate resource because of jurisdictional barriers to exercise of the state's police power to involuntarily commit reservation Indians, the conclusion followed that the IHS alternate resource rule did not apply, and the IHS should pay for the plaintiff Indian's care.

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*/ The alternate resource rule considered by the court in White was the rule set out at 42 CFR §36.12(c). The White case was decided in 1977, prior to promulgation of 42 CFR §36.23(f) in regulations specifically governing contract health services on August 4, 1978.

However, the court bolstered this conclusion by referring to the following declarations of findings and policy in sections 2 and 3 of the Indian Health Care Improvement Act, 25 U.S.C. 1601 and 1602:

> The Congress finds that:
>
> (a) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique relationship with, and resulting responsibility to the American Indian people.
>
> (b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.
>
> The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligations to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing health services with all resources necessary to effect that policy.

The court viewed these congressional statements as confirming the federal trust responsibility to Indians in the area of health care. The court determined that this trust responsibility required that the IHS not abandon the plaintiff given that South Dakota had no obligation to pay for the plaintiff's care.

The court's reliance on the federal trust responsibility to hold that the IHS should pay for plaintiff's care was unnecessary, since the IHS had never contended that it would abandon the plaintiff, who was otherwise eligible for contract health services, in the absence of a state responsibility to pay. Moreover, the context of the court's discussion of the federal trust responsibility precludes reading the court's decision as a constraint upon agency power to adopt the alternate resource rule. The court in White did not hold that the trust responsibility, as enunciated in the Indian Health Care Improvement Act, precluded adoption of the alternate resource rule. It merely found the rule inapplicable in the special circumstances of that case, and defined the agency responsibility accordingly. */ The jurisdictional considerations regarding involuntary commitment that in the court's view foreclosed state responsibility serve to distinguish that case from the vast majority of situations (such as the case here before this Court) in which health care is obtained by Indians from non-IHS providers without the need for involuntary commitment.

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*/ Federal defendants recognize that the Federal Government has a special relationship and responsibility to Indians in the area of health care. The statements of findings and policy in sections 2 and 3 of the Indian Health Care Improvement Act confirm this. However, those statements do not provide Indians with a legal entitlement to contract health services precluding adoption of the alternate resource rule as a limitation on benefits. The Supreme Court has noted that although statements of findings and policy in federal statutes may support appropriations, they are not viewed as providing specific entitlements. Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, 20 (1981).

We conclude that the Secretary (HHS) has the legal authority to create eligibility requirements for IHS contract health services provided the Secretary does so by regulations rationally related to program goals. The alternate resource rule at 42 CFR §36.23(f) is such a regulation. It has been promulgated in accordance with rulemaking procedures and thus meets the procedural requirements set forth in the Ruiz decision. It is rationally related to program goals in that it is designed to stretch limited contract health service dollars for the benefit of the entire IHS service population by taking into account the Indians' rights to other benefits as state citizens.

D. The IHS properly viewed Roosevelt County as an alternate resource for payment of James' bills.

Federal regulations at 42 CFR §36.21(a) define the term "alternate resources" as follows:

> (a) "Alternate resources" means resources other than those of the Indian Health Service contract health services program, available and accessible to the individual, such as health care providers and institutions (including facilities operated by the Indian Health Service), health care payment sources, or other health care programs for the provision of health services (e.g., medicare or medicaid) for which the individual may be eligible.

Although this definition does not specifically mention county medical assistance programs, such programs are a "health care payment source" and, therefore, may be reasonably viewed as within the scope of the above definition of "alternate resources." A Federal agency's interpretation of its own regulations is entitled to deference by the courts. Bowles v. Seminole Rock & Sand Co., 325 U.S. 410 (1945); United States v. Whelan, 463 F. 2d 1093 (9th Cir. 1972).

There is no factual dispute in this case that James is an indigent person who meets the eligibility criteria for county medical assistance. The state hearing officer specifically found this to be the case and county defendants have admitted in answering Federal defendants' interrogatories that the sole basis for County defendants' refusal to pay James' bills is their insistence that the IHS is responsible (See Exhibit C, 2(b) and (c).) County defendants do not claim that James is otherwise ineligible for county medical assistance and in fact have paid James' mother's medical bills.

Given these factual circumstances, the IHS determination that Roosevelt County is an alternate resource for payment of James' hospital and medical bills is rational and proper.

E. Roosevelt County's policy of considering the IHS contract care program as a prior resource is illegal under Montana law

By its actions in refusing to pay James McNabb's medical bills, as well as by its general policy of considering IHS to be a prior resource to its county medical assistance program, Roosevelt County is in violation of Montana Law.

1. Roosevelt County has completely ignored two Montana DSRS decisions holding the County responsible for James McNabb's bills

The County has simply ignored two DSRS decisions holding that the County is responsible for James' medical bills. These two decisions -- the January 17, 1983 written decision of the DSRS hearing officer after a fair hearing procedure (Exhibit A) and the March 1, 1983 written affirmance of that decision by the State Board of Social and Rehabilitation Appeals (Exhibit B) -- constitute final State agency action. In the January 17, 1983 written decision, the hearing officer made the following "findings of fact," among others:

> That the Indian Health Service has denied payment of the bills in question because an alternate resource is available, namely County Medical Assistance from Roosevelt County.
>
> That the IHS is a residual resource for care for Indians, as a result they do not have individual entitlement to medical care through the IHS.
>
> That Ms. McNabb and James McNabb have equal enjoyment of and full entitlement to benefits provided other State citizens.
>
> That there is no legal basis for considering the IHS as a prior available resource for county medical assistance... (Emphasis added.)

In the hearing officer's decision, the following "ultimate findings of fact," among others, were made:

> That Pamela Keller McNabb was indigent and unable to provide for the costs of childbirth in relationship to her son, James McNabb. That she is indigent within the meaning of Section 53-3-103(1) [Montana Statutes].

> That Roosevelt County must meet James McNabb's needs as an indigent citizen independent of other sources. To avoid responsibility under the guise of Indian Health Services is unlawful and unfair.
>
> * * *
>
> That the IHS is a discretionary program and administered on the basis of professional and administrative judgment with regard to priorities of need, availability of other arrangements for obtaining care, and the allocation of limited fiscal and personal resources.

In refusing to pay for James' medical bills, Roosevelt County is clearly violating the holding of a Montana Supreme Court case, County of Blaine v. Moore, 568 P.2d 1216, 1222 (Mont. 1977), which is factually very similar to the instant case and which held that a county medical assistance program may not refuse to pay for an individual's benefits, when it has been ordered under State law to do so, while pursuing a challenge of the Federal government's denial of benefits to the individual. In the Blaine case, Blaine County, Montana, was challenging several issues surrounding a DSRS administrative decision, like the one in the instant case, holding the County liable for certain medical assistance benefits. One of the things Blaine County was challenging was the hearing officer's failure to find IHS the resource responsible for satisfying the medical bills of the individuals involved. As in the instant case, Blaine County contended that it could deny county medical assistance to the individuals in question because IHS was responsible for providing medical care to them. The Montana Supreme Court's response to that issue was, in pertinent part, as follows:

> The evidence clearly establishes that the Indian Health Service refuses to give medical assistance to the Moores. 42 CFR 36.12 [the predecessor regulation to 42 CFR 36.23(f)] indicates that there may be regulatory justification for the Indian Health Service's denial of medical assistance to the Moores...
>
> * * *
>
> In any event, we fail to find merit in Blaine County's argument that the Moores must litigate a potential right to federal resources prior to seeking county welfare medical assistance. Upon being denied federal assistance, the Moores elected to apply for county welfare medical assistance and under the circumstances they are entitled to such assistance.

2. In denying payment for James' medical bills, Roosevelt County relied on a Montana regulation which had been repealed.

In their responses to the Federal defendants' interrogatories (Copy attached as Exhibit C), the County defendants stated that February 8, 1982 was the date on which they first denied county medical assistance for the payment of Pamela Keller McNabb's medical bills and those of her minor son, James. The County defendants admit that on November 15, 1982, the County reconsidered its initial decision and agreed to pay Pamela's bills, but not James'. When asked why they made this decision the County responded as follows:

> Roosevelt County made a verbal agreement with Legal Aid Attorney, Sarah Arnott, who stated that if we agreed to pay Pamela McNabb's (non-Indian) medical bills she would get IHS to pay James McNabb's (Indian) medical bills. (Exhibit C, 2(b).)

In response to the Federal defendants' question of whether the County's continuing decision not to pay for James' bills was based on the County's reliance on A.R.M. 46.9.509(1)(b), the County responded "yes".

Montana regulation A.R.M. 46.9.509(1)(b), upon which the County defendants admit that they were relying in November 1982, in continuing to deny James' benefits, was no longer a valid regulation at the time they relied on it. The rule had been repealed effective August 13, 1982. (See Exhibit F. Also see pages 11-12 of McCabe Deposition, in which Mr. McCabe discusses the repeal of the rule.) The rule was declared to be unlawful by DSRS' legal counsel, Dal Smilie, in March 1982. In a March 24, 1982 opinion (copy attached as Exhibit G), Mr. Smilie stated, in pertinent part, as follows:

> ARM 46.9.509(b) lists Indian Health Service as a resource to be utilized before county medical is utilized. This is not good law today and hasn't been since County of Blaine v. Moore & St. James Community Hospital, 174 Mont. 114, 568 P.2d 1216 which was decided on September 14, 1977.

Thus it is clear that the County defendants had no legal basis for their decision (in November 1982) to deny payment for James' bills. In addition, in light of Mr. Smilie's statement that the rule hasn't been good law since the 1977 Blaine case, the County defendants had no valid legal basis for initially denying the claims of both Pamela and James in February 1982.

3. Roosevelt County is in violation of Montana Law by continuing to operate its medical assistance program under the repealed rule.

Roosevelt County is now, and was in 1982 when it denied responsibility for James' bills, violating Montana law by the manner in which it is operating its county medical assistance program. In their answers to Federal defendants' interrogatories, the County defendants admit that the County does not have an approved county medical assistance plan as required by A.R.M. 46.9.407(1), which provides, in pertinent part, as follows:

> 46.9.407 COUNTY PLAN (1) Counties shall write their own general assistance and medical rules which then must be approved by the department to be effective prior to implementation.

In his deposition, Mr. McCabe of DSRS stated that Roosevelt County did not have an approved plan in 1982 and does not have one currently. (See Exhibit D, McCabe deposition, at pp. 9-10). Mr. McCabe also stated that DSRS has disapproved portions of county plans which listed IHS as a prior resource. (See McCabe deposition, Exhibit D, at pp. 14-15 and Exhibit E, pp. 1-4.) Thus it is clear that Roosevelt County's past and current policy of relying on the IHS as a prior resource would not be an approvable policy under DSRS rules.

In responding to interrogatories, Roosevelt County further admitted that it is out of compliance with A.R.M. 46.9.407(1)(b), which requires counties without approved plans to use the maximum income and resource assets criteria of the State's Medicaid program. (See Exhibit C, 1(h)(i)). Under the medicaid eligibility rules, it is impermissible to rely on IHS as a prior resource. (See McCabe deposition at p. 14 and the October 18, 1983 letter from Russell E. Cater, Chief Legal Counsel, DSRS, to James R. Halverson, Chairman, Roosevelt County Commissioners, attached as Exhibit O, which states, in pertinent part: "Please note that Indian Health Services cannot be considered as a prior resource by either that rule [medicaid eligibility criteria] or by any county plan this Department could approve"). Mr. McCabe, in his deposition, stated that Roosevelt County was not following the medicaid rules at least insofar as the County was considering IHS as a prior resource. (See McCabe deposition at page 10.) The County admitted that it was making eligibility determinations for county medical assistance on the basis of its plan which had been disapproved by DSRS. (See Exhibit C, 1(f)(i).) The County also stated in its answer to an interrogatory that in calendar years 1982 and 1983 it had not awarded county medical assistance to any Roosevelt County Indian residents. (See Exhibit C, 7.)

It is clear that the County's county medical assistance program policy of refusing to pay for services to Indians on the basis that IHS should pay first is illegal under Montana law. In addition, in the particular instance of refusing to pay for James McNabb's medical services, which is at issue in this case, the County is violating State law, specifically a final State agency determination holding the County responsible (and which the County never took any action to appeal in State court).

F. Roosevelt County's policy conflicts with Federal law

1. The County's policy cannot prevail under the Supremacy Clause

The County's policy of refusing to pay for medical services for Indians on the basis that IHS should pay first is in clear conflict with Federal law which provides exactly to the contrary. As shown in sections C and D above, the IHS alternate resource rule is a valid Federal regulation and the Secretary's determination under that rule that Roosevelt County's medical assistance program is an alternate resource is a reasonable one. As discussed in section E above, the Secretary's position that the IHS is residual to Roosevelt

County is supported by Montana law as well. As noted above, the IHS regulation is intended to preserve the Indian's right, as a citizen, to State and County benefits by limiting the Indian's eligibility for IHS contract health services. Under the Federal rule, Roosevelt County may not presume that an Indian has a right to IHS contract health services which may be invoked to deny county medical assistance. Roosevelt County admits that it is making that presumption. Because the County's policy is in obvious and direct conflict with the Federal regulation, it is clear that under the Supremacy Clause of the Constitution (Article VI, Clause 2), the Federal rule, and not the County's policy, must prevail. *See Blum* v. *Bacon*, 457 U.S. 132 (1982), in which the Supreme Court invalidated two New York rules which conflicted with a valid Federal (Department of Health and Human Services) regulation.

2. The County's Policy Results in Invidious Discrimination Against Indians by the County

The County defendants have asserted in their Answer and Cross Claim filed on May 31, 1983 that the county is not *per se* discriminating against Indians by refusing to pay for their medical benefits. Instead, the County states that Indians are being denied services because they have a resource for payment (IHS). The County asserts that the denial of benefits to Indians on the basis that the IHS contract care program will pay is no different than denying county medical assistance to someone because he or she has too much money in the bank or has hospitalization coverage. However, as the arguments above clearly show, the County has no legal basis for considering the IHS contract care program as a prior resource. Under Federal law and Montana law it is not an entitlement program and it cannot be so considered by the county. By continuing to rely on its illegal policy as an excuse to refuse to serve Indians, the County is clearly discriminating against Indians and violating their rights under the Equal Protection Clause of the Fourteenth Amendment.

The County in its May 31, 1983 Answer and Cross Claim stated that Indians in the County pay no taxes and "contribute little or nothing to funds available for medical services for indigents." The County further asserted that:

> Roosevelt County and its taxpayers will suffer irreparable harm, damage and injury if Roosevelt County is ordered to pay the medical expenses for James McNabb not to mention all other indigent Indians in Roosevelt County not subjects of this lawsuit.

Thus it appears that the County is refusing to provide county medical assistance for Indians not just based on their erroneous presumption that IHS is a prior resource, but also because the County does not want to serve Indians because Indians do not contribute to the medical assistance fund through the payment of taxes. However, as the case law makes abundantly clear, Indians are State citizens, and as such are constitutionally entitled under the Equal Protection Clause of the Fourteenth Amendment to State privileges and services provided to other State citizens. State ex rel Williams v. Kamp, 78 P.2d 585 (Mont. 1938); Acosta v. San Diego County, 272 P.2d 92 (Calif. 1954); Little Thunder v. South Dakota, 518 F.2d 1253 (8th Cir. 1975), United States v. Apache County, Arizona, 429 U.S. 876 (1976), aff'g mem. Civil No. 74-50 (D. Ariz. 1975); Prince v. Board of Education, 543 P.2d 1176 (N.M. 1975). Since the county's medical assistance program is clearly mandated by State law, it is clear that the County may not treat Indians differently from other citizens regardless of the Indians' contribution to the State or county tax base.

The Acosta case, supra, involved the issue of whether an indigent Indian residing in a California County was eligible for direct county relief. The county argued, among other things, that because reservation Indians were not subject to State and county taxes, they were not entitled to receive the benefits that such taxes provided. However, the California District Court of Appeal affirmed the lower court's judgment against the county, holding in pertinent part, as follows:

> The issue of whether Indians living upon reservations are subject to state laws and taxation is not necessarily pertinent to the issue before us. Many non-Indians

> in San Diego County live upon tax-exempt property belonging to federal or local government agencies or to religious institutions, but in no such case has this fact been considered a justification for the withholding of any public services ....(W)hile benefits have been granted by the federal government to members of various Indian tribes, these benefits are no different in character from those allowed to many other classes of citizens, such as federal employees, holders of tax-exempt securities and veterans. In no case has the enjoyment of such special rights or privileges served as a justification for the exclusion of any such favored group from participation in the ordinary rights of citizenship, including the right to equal treatment under state welfare laws. 272 P.2d at 98.

The United States Supreme Court case of Shapiro v. Thompson, 394 U.S. 618 (1969) also makes it absolutely clear that a State may not protect the public fisc by invidiously discriminating against certain classes of persons. Shapiro involved a District of Columbia one-year residency requirement for receiving welfare aid which the Court struck down. While the facts of the cases are different, the Court's discussion of invidious discrimination is certainly on point in the instant case:

> We recognize that a State has a valid interest in preserving the fiscal integrity of its programs. It may legitimately attempt to limit its expenditures, whether for public assistance, public education, or any other program. But a State may not accomplish such a purpose by invidious distinctions between classes

> of its citizens. It could not, for example, reduce expenditures for education by barring indigent children from its schools. Similarly, in the cases before us, appellants must do more than show that denying welfare benefits to new residents saves money. The saving of welfare costs cannot justify an otherwise invidious classification. 394 U.S. 633 (footnote omitted).

Also see Memorial Hospital v. Maricopa County, 415 U.S. 250, 263 (1974). Thus, it is clear that Roosevelt County may not legally deny county medical assistance to its Indian residents, as it did to James McNabb, on the basis that it will save the County money or because Indians do not pay into the system. By continuing to deny the program's benefits to Indians, Roosevelt County is invidiously discriminating against them, denying them equal protection of the law under the Fourteenth Amendment.

CONCLUSION

The Federal Defendants have demonstrated, based on the undisputed facts, that (1) the IHS alternate resource rule at 42 CFR § 36.23(f) is a valid Federal regulation promulgated within the scope of the Secretary's authority, (2) the IHS determination that Roosevelt County is an alternate resource for payment of James McNabb's medical bills is rational and proper, (3) Roosevelt County's refusal to provide county medical assistance to James McNabb violates Montana law, (4) Roosevelt County's policy of considering the IHS contract care program to be a prior resource is invalid under the Supremacy Clause because it directly conflicts with a Federal regulation, and (5) Roosevelt County's continued refusal to pay James' medical bills under these circumstances constitutes invidious discrimination by violating James' right to equal protection under the Fourteenth Amendment. For these reasons, Federal defendants' motion for summary judgment should be granted.

DATED this _________ day of April, 1984.

Respectfully submitted,

BYRON R. DUNBAR
United States Attorney

By: ________________________
CARL E. ROSTAD
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(ATTACHMENTS NOT INCLUDED)

Senator MELCHER. That is fine. Now let us get back to the budget hearing. You submit the legal documents that you want to. That is fine, but let us get back to the present.

Do you maintain that there is less Federal responsibility for indigent Indians?

Dr. GRAHAM. I cannot discriminate in the Federal responsibility under the statutes, or the treaties, or the appropriations for individual Indians, whatever their socioeconomic status may be; as we provide care through the Indian Health Service, we do provide care which in our view is residual to other resources. We look to see whether or not an individual presenting himself or herself for care is eligible for reimbursement of that care or eligible for services under some other provider. That allows us to stretch the dollars made available to the Indian Health Service further and to provide more care to more Indian people.

Senator MELCHER. That is a glorified statement, Doctor, and I would not quarrel with it a bit, but the point is that this language I have read to you refers to indigent Indians. Now, if you sign an Indian for health care purposes who is not indigent, where is that money going to come from? If you assign a nonindigent, non-Medicare Indian patient to a private hospital, are you going to pay the bill?

Dr. GRAHAM. We will pay an amount of the bill based upon our negotiations with that hospital, our availability of funds under the contract health care appropriation in that year, and after reviewing whether or not that individual has any other source of care.

Let us take a 47-year-old Indian individual, nonindigent admitted to a non-IHS hospital for a perforated ulcer. We would look first to see whether or not that individual has private insurance. If that individual has private insurance because he or she happens to be employed, we would require the hospital to seek reimbursement from that insurance company prior to the time that we would use Indian Health Service funds. Because, if the hospitalization for that individual with a perforated ulcer would cost $3,500 and private insurance will pick it up, that is $3,500 we do not have to spend out of the contract health care pot that is available for expenditure later on when some other individual has to be admitted for another cause and does not have insurance, Medicare, Medicaid eligibility, county eligibility, or anything else.

That is exactly the way we run the program and exactly how the residual rule is applied.

Senator MELCHER. I know, Doctor, you would not fence with me on answering these questions, so what is the rest of the response?

Dr. GRAHAM. I am sorry. I——

Senator MELCHER. Say there is no health insurance or the health insurance pays $1,500 of that $3,500.

Dr. GRAHAM. If there is no health insurance, there is no county eligibility, there is no city program, there is no indigent care program for other citizens, if there is nothing, that is where the Indian Health Service meets the bill.

Senator MELCHER. And that Indian is not indigent?

Dr. GRAHAM. The status of indigency is not the status which determines our decisions.

Senator **Melcher**. So, there is absolutely a different rule and a different procedure than for the nonindigent and the indigent.

Dr. **Graham**. No; I think that what I have described for you is that exactly the same rules are applied to everyone without regard to socioeconomic status. The primary proecdure we go through when the individual comes in is not to say are you indigent or nonindigent. The primary rule is to say are you eligible for any other support, Medicare, Medicaid, county, city.

Senator **Melcher**. That is one rule.

Dr. **Graham**. No; that is the only set of questions that we work through.

Senator **Melcher**. But the way your premise works out, there is a greater Federal responsibility that you assume through Indian Health Service for the nonindigent than there is for the indigent.

Now, tell me this, Doctor, what is that hospital supposed to do if they do not have any money?

Dr. **Graham**. In what sense?

Senator **Melcher**. Refuse a patient?

Dr. **Graham**. If the hospital does not have any money, the hospital is not in operation.

Senator **Melcher**. Let us not fence. They do not have any money, they do not have any extra money, they are in operation, and what are they supposed to do? It is going to be a loss to them.

Dr. **Graham**. In those circumstances, to the best of the Indian Health Service ability, we pay the bills as much as is available under the appropriation.

Senator **Melcher**. I think you are wasting my time. I think you are wasting the time of all of the people that work under you. I think you are wasting the time of these hospital staffs in the counties, and furthermore, I think it is demeaning to Indian people to try to quibble around what is and what is not the Federal responsibility. These hospitals in many States, mine included, that are adjacent to a reservation are often funded out of county funds and a combination of funds also, some of which is derived from the State.

It is not a question of whether or not these Indian people are contributing to the paying of the bills of the hospitals through a tax base. Indigent Indians are not, and primarily the tribes are not. Their property cannot be taxed. So, it is clear there is a need, and it is clear that the longer we fence around this, we are wasting people's time, and we are wasting probably money out of the Indian Health Service funds by you people drawing up the rationale which, Doctor, I have to say, is very strained, for not recognizing, as IHS has in the past, that there is a clear Federal responsibility that is primary and you should meet it out of appropriated funds.

Congress has the power and Congress has the authority, if Congress wants to do it, despite the veto, this being one of the reasons for the veto of the previous bill, and the Congress can act. If the President wants to veto, he can, but I think on this question it is clear enough and easily enough understood that perhaps Congress can be persuaded to pass it overwhelmingly and it will not become an item for a veto.

Thank you for your answers. I will look forward to the legal citations just as a matter of background, but the point is well made and has been carried out. It has been backed up for generations that you just do not try to measure whether it is an indigent or a nonindigent. You do not foist off the bill onto a local hospital just because you think they can tap some other sources.

Dr. GRAHAM. Senator, I am sorry if you feel that we are wasting your time. I feel that that provision is an infringement on some basic rights of Indian people.

Senator MELCHER. Oh, Doctor, that is a ridiculous argument. That is like saying that Indians ought to be subject to the Montana State Fish and Game authorities on their own reservations because if they are not, they are denied that opportunity. These are treaty rights. They are not something grabbed out of the sky. We are not denying anybody the opportunity to fully participate as citizens. What we are talking about is a right beyond basic citizenship as a U.S. citizen. These are native Americans who, through the treaties, have a special right to health care, and it is a question whether that is going to go in a uniform matter as it used to do to the indigents regardless of whether they are indigent or not. This is not a question of denying somebody a right. This is a privilege and a right based on treaties above the ordinary privileges and rights of a citizen.

Dr. GRAHAM. Senator, I have had the opportunity to talk with individuals who have been in the Indian Health Service for a number of years. I do not believe, based upon those conversations, it is fair to say that this is a change in IHS policy. You will see that when I submit the documentation for the record which has to do with the development of this policy and the court cases. You and I, I believe, are in agreement when we talk about treaty rights being over and above the basic rights of citizenship, but to me a basic right of citizenship is whatever public programs are provided at a city or county level to whomever the citizens happen to be.

Senator MELCHER. Doctor, if you want me to document what the experience of hospitals are and you are not aware of them, I would be glad to give you a good sampling. Would that be helpful? They have been there just as long as any IHS people have been around the reservations in these communities.

Dr. GRAHAM. I would be happy to, although I suspect I have some idea of what is going on with rural hospitals because that is the part of the country that I come from also. Those are a set of issues on which this is but a part, but it is a far broader set of issues than just this.

Senator MELCHER. Thank you, Mr. Chairman.

Senator ANDREWS. Thank you, Senator and thank you, Dr. Graham. Your prepared statement will be entered in the record at this point.

[The statement follows:]

PREPARED STATEMENT OF ROBERT GRAHAM, M.D., ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee, I am Dr. Robert Graham, Administrator of the Health Resources and Services Administration. With me is Dr. Everett Rhoades, Director of the Indian Health Service (IHS). I am very pleased to be here today to discuss with you and your Committee the reauthorization of the Indian Health Care Improvement Act, P.L. 94-437. We consider principles embodied by this Act to be the keystone to the continuing goal to raise the health status of the American Indian and Alaska Native people to the highest possible level.

It was P.L. 94-437 which, for the first time, established parity as a benchmark to measure our efforts to reach this goal. It requires the Secretary to assess the programs established or assisted under this Act to determine additional steps necessary to insure that the health status of and the health services available to Indians are "at a parity with the health services available to, and the health status, of the general population". The determination as to what steps are necessary to continue our progress is reflected in the proposed FY 1986 budget on which I testified before this Committee last week.

Mr. Chairman, given the confusion arising from the President's veto of a similar bill last year, I think it might be useful to review briefly the reasons for his veto, to examine the programmatic effects of the veto, and to comment in general terms on the degree to which this bill addresses the concerns raised in the President's Memorandum of Disapproval.

The President witheld his approval of S.2166 last year for the following reasons: first, he objected to the provision making certain Indians ineligible for certain state and locally provided health care benefits; second, he objected to the unconstitutional mechanism by which the Indian Health Service would be removed from the Health Resources and Services Administration; third, most of the bill's provisions duplicated existing authorities; fourth; the bill would have unnecessarily changed the organizational structure of the Indian Health Service; fifth, the bill would have increased IHS responsibility for services only peripherally related to IHS's primary mission; and sixth, and by no means least, the authorization levels in S.2166 were excessive.

In his Memorandum of Disapproval, the President made it clear that the veto would have no adverse impact on the ability of the IHS to continue to provide quality health care to American Indians and Alaska Natives. Today, over five months into fiscal year 1985, I am pleased to report to you that the broad authority of the Snyder Act has permitted the IHS to continue to provide its entire complement of health care and health care-related services.

In the context of the President's veto message, let me comment briefly on S.277. We applaud removal of the two provisions regarding Indians' eligibility for State and locally-provided health care benefits and the unconstitutional transfer mechanism. However, the bill retains a number of objectionable features. In general terms, the bill retains duplicative authorities, unnecessarily interferes with the organizational structure of the Department of Health and Human Services, inappropriately expands IHS responsibility into areas only indirectly related to primary health care delivery, and contains excessive authorization levels.

The Indian Health Care Improvement Act is a keystone of our overall efforts. The Act is designed to maintain a health care system which provides high quality health services to the Indian people. Increases in financial and human resources are aimed at strengthening an infrastructure capable of meeting the national goal of raising the health status of the Indian people to the highest possible level and of encouraging the maximum participation of the Indian people in the planning and management of these health systems.

The primary method provided by Congress for the Indian people to exercise maximum participation in the management of these health systems was the Indian Self-Determination Act, P.L. 93-638, which provides tribal governments with the right to take over the operation of most Indian Health Service programs serving them. Nevertheless, the Congress saw that the health systems serving Indians should meet the standards available to the general population before it would be feasible for tribes to assume control. The Indian Health Care Improvement Act was the method chosen by the Congress to bring the Indian health system up to a level comparable to the general population and thus position those tribes, which so chose, to utilize P.L. 93-638.

The linkage between P.L. 94-437 and P.L. 93-638 does not mean that the two laws are totally interdependent. P.L. 93-638 goes beyond health care and addresses the issue of tribal sovereignty. Consequently, we recommend that issues involving Indian Self-Determination not be considered as part of the reauthorization of P.L. 94-437. In addition to clouding health care issues, we believe that all the tribes deserve the opportunity to consider changes affecting Indian Self-Determination in a forum that has self-determination as its prime, if not its only, purpose.

We are concerned about including in an Indian health improvement bill any provisions that go beyond establishing health improvement goals. I speak particularly about a number of provisions that deal with California. Those California provisions that would amend P.L. 93-638 should be addressed separately and not in the context of P.L. 94-437. In addition, however, we are opposed to the provision in section 705 that would provide a separate and special legislative definition of California Indian eligibility for IHS services. We recognize that there are unique problems in California, but we do not believe those problems center around the definition of eligibility for IHS programs nor that it would be wise to attempt to correct a localized historical problem in legislation aimed at a nationwide program.

The Indian Health Care Improvement Act, in conjunction with the Indian Self-Determination Act, represents almost a decade of effort to establish a framework within which Indian people can effectively participate in deciding their role in health programs developed to serve the Indian community.

To achieve the intent of the Congress, the IHS, within the framework of self-determination and the provisions of this law, established three precepts:

1. Continue improvement of health programs for Indians in ways that expedite health status elevation and result in health delivery systems which lend themselves to successful local management.
2. Maximize the American Indian and Alaska Native awareness of and participation in all health programs for which they are eligible on the same basis as all others who qualify; and maximize those programs' awareness of the need and efficacy of special efforts to make benefits available and accessible to the American Indians and Alaska Natives.
3. Accelerate development of Indian communities' capacities to staff and manage their own health programs to such extent as they may choose.

During the period that these precepts have been in force, significant improvements in the health status of Indians have been achieved. Nevertheless, disparity remains in the health status of Indians when compared to that of the U.S. general population. Mortality is still 7% higher than that of the U.S. white population, based on 1982 age-adjusted rates. With the foregoing concerns in mind, the Department has developed a legislative proposal which we believe clearly focuses on the goals of P.L. 94-437.

I would like to now turn to some of the specifics contained in S. 277.

Title I, Indian Health Manpower, should be extended for three years but authorize only such funds as may be necessary to fund students who had been funded by October 1, 1985.

The Department does not believe there is any need for the proposed section 105(d) of the Act that would restrict stipend payments when students are working for IHS under the section 105 Extern Program. Stipend payments for "Health Professional Preparatory Scholarship" recipients (section 103) are already limited to periods when the recipients are attending school full time. In addition, the Department is opposed to applying this restriction to Indian Health Scholarship recipients (section 104 i.e. sec 338G of the PHS Act) since this would treat them differently from other National Health Service Corps Scholarship recipients and act as a disincentive to their working for IHS during non-academic periods. Under the proposal, such students would be entitled to retain their stipend if they worked for someone other than IHS. There are immediate and long term career benefits accruing to IHS and its service population by encouraging these scholarship recipients to work for IHS during non-academic periods.

The proposed section 201, Health Services, has excessive reporting requirements along with required procedures which would place a tremendous administrative burden on IHS and the Indian tribes. The proposal mixes health care improvement, fixed priorities, planning, and equity issues into a single process which we believe is counter productive.

The proposed new section 201(b)(2) deals with P.L. 93-638 contracts establishing a limit of 15% on P.L. 93-638 funds which can be used for health planning, training, technical assistance and administrative support functions. It is unclear if the restriction applies to the contractor, to IHS, or to both. If administrative support functions include expenses generally covered by indirect costs, we are concerned that P.L. 93-638 contractors would be limited to a 15% indirect cost rate.

The Department supports the extension of the authority to expend funds for research contained in the proposed new section 201(e), but opposes authorizing such research under P.L. 93-638 contracts which, because of their mandatory nature, are not suitable instruments for research contracts which must be with entities that already have the needed expertise to address the subject being researched.

The Department does not believe a separate and additional authorization (as proposed by section 202 of S.277) is required to establish a Catastrophic Health Emergency Fund to deal with extraordinarily expensive illnesses or accidents occurring to Indians served by either IHS or IHS funded programs. The IHS, as a health system, is able to shift available resources to cover these incidents. The Department supports in principle the effort to rationalize and institutionalize the current IHS efforts to deal with this increasingly important problem.

The Department does not believe the competitive bidding for health services is a problem under the implementation policies and procedures currently in place. The Department has the authority to waive the competitive bidding process when necessary and its policies and procedures reflect this authority. Therefore, the Department does not believe there is any need for authority to waive competitive procurement as provided in section 203 of the bill. Moreover, the Department opposes the provision that would require the Secretary to waive competitive bids simply on the basis of a certification from the responsible "Chief Medical Officer" that accessibility, quality, or continuity of care would be endangered.

Health promotion and disease prevention is a major emphasis of the IHS and we support the clear statement of policy and goals in section 204(a). We do not, however, support section 204(c) which provides for an extensive system of reports, regulations and tribal plans which we believe would divert scarce resources from health promotion and disease prevention services.

We support a simple extension of the existing section 301 of the Indian Health Care Improvement Act, Construction and Renovation of Service Facilities, rather than the version contained in S. 277 which we believe has excessive reporting requirements and inappropriate administrative provisions.

The President's FY 1986 budget requests no funds for construction of new service facilities. In considering the FY 1987 budget, the Administration will re-evaluate without prejudice any IHS plan to construct new service facilities.

We believe there is a particular problem with the proposed new section 301(d) dealing with the closures of facilities. Any provision governing closures should permit a waiver of the one year notice where good cause exists, either fiscal or medical. We also recommend that any such provision not apply to temporary closures or to closures of a portion of a facility. Specific services representing a portion of a facility must periodically be curtailed or closed because of a multitude of reasons such as changing medical procedures, and changing demographics and other factors that would alter the demand on health services. The provision, as drawn, is far too broad in scope and would adversely affect the IHS management of the facilities.

With regard to section 302 of P.L. 94-437, Construction of Safe Water and Sanitary Waste Disposal Facilities, we support amending the section to permit the Indian Health Service to continue to administer funds made available under other appropriations for the construction of sanitation facilities. The Administration is requesting no direct Indian Health Service appropriation for the construction of sanitation facilities in FY 1986, but recognizes that IHS expertise in this area could be useful to other agencies responsible for Indian housing.

In addition, the Department opposes language in the proposed new subsection 302(d) that would result in IHS constructing and operating sanitation systems for tribes that the Secretary has determined do not have, and can not reasonably be expected to develop, the necessary technical capacity to operate systems on their own. The IHS has been very successful, and is expected to continue to be successful, in assisting tribes in developing the competence necessary to operate and maintain sanitation facilities. The percentage of systems in place and operating at an acceptable level of competence compares very favorably with rural systems run by the general population.

The local control and responsibility of tribes and Indian communities to operate and maintain the water and sanitation systems has been one of the major strengths and sources of success of the program. The proposal would act as a disincentive to tribes currently doing a responsible job.

The Department supports the proposed change in the Medicare and Medicaid law, as proposed in Title IV of S.277, which would authorize payment to IHS for any covered service under the same condition of participation applicable to other providers.

The Department supports extension of section 404 which authorizes grants and contracts with tribal organizations to improve Indian access to the Medicare and Medicaid programs. The Department also supports the demonstration programs for direct billing of Medicare, Medicaid, and other third party programs contained in the proposed new section 405. Both of these provisions would be supportive of the Department's efforts to increase third party payments for Indian health.

The Department does not believe there is any need for the study of barriers to Indian participation in Medicare and Medicaid as called for by the proposed new section 406. The demonstration and section 404 projects, along with experience, should be sufficient to identify problem areas. Experience has also shown that legislation is not always the solution to such problems. Where problems do call for a legislative solution, we will propose legislation as in the case with the proposed revision to sections 1880 and 1911 of the Social Security Act.

The Department strongly opposes the proposed extension of Title V of the Indian Health Care Improvement Act, Health Service for Urban Indians, and no funds are requested for this purpose in the President's budget for FY 1986. Existing State and community based health organizations currently absorb most of the clinical workload of the urban Indian projects. These projects have demonstrated their ability to generate revenue from other sources. Reduction of direct Federal support should not drastically change the ability of the community to provide linkages that have been established by the urban Indian projects and the funds being generated from other sources by these projects.

Section 602 of the bill would establish the Indian Health Service as an agency of the Public Health Service within the Department of Health and Human Services. The Department sees no demonstrated need nor any advantages in removing the IHS from the Health Resources and Services Administration (HRSA). We believe the Indian Health Service should continue to be located within HRSA in order to take advantage of the available health services expertise. Given the significant improvement in Indian health over the past thirty years, the IHS should continue as a bureau of the primary health services agency of the PHS, i.e., HRSA.

There are strong arguments in support of IHS remaining a component of the Health Resources and Services Administration. We have made major strides toward our goal of providing the highest possible health status to the Indian people and Alaska Natives. We believe that the present organizational structure enhances this effort, and the allegation that IHS is not sufficiently visible or that it does not have enough access to Department leadership is unfounded. It is the largest bureau within HRSA. HRSA also administers most of the health services delivery programs of this Department including the National Health Service Corps, many of whose members are recruited for, and serve in, the IHS. To disturb the existing good working relationships among these programs could impede the progress of IHS rather than accelerate it. We do not think it would be in the best interest of Indian health to be locked into a specific legislative solution without first a careful consideration of the above concerns. We therefore oppose section 602.

The Department opposes section 701 of the bill which would amend section 704, of the Indian Health Care Improvement Act, Leases with Indian Tribes, as we believe it would result in excessive payments for property leased from tribes in that IHS might have to pay for depreciation even where the funds for construction of the property were provided by the Federal government. In addition the proposed new section 704(b)(3) could require IHS to make payments for facilities it owned. We believe the cost principles applicable to all other entities leasing property to the Federal government are adequate and that there is no justification for special principles applicable only to Indian tribes.

The Department supports the intent of section 702 of S.277 which would initiate a program aimed at alcohol and drug abuse among Indian youth. Juvenile alcohol and drug abuse has reached epidemic proportions in many Indian communities. The problems are such that the interagency cooperation called for in the proposal is essential if any success is to be achieved. We believe, however, that legislation is not needed to accomplish the goals of this section. In any event, the time frame to enter into an interagency agreement is unrealistic and does not allow sufficient time to assure full consideration of the needs of such an agreement. FInally, we oppose the statutory establishment of an Office of Alcohol and Drug Abuse with a mandated organizational structure, and believe that such decisions are better handled administratively.

The Department opposes section 703 of the bill which would authorize a study of nuclear development health hazards on Indians and Indian miners. Such a study was called for by section 707 of the current law, has been completed and was submitted to the Congress on April 27, 1983. The Department does not believe there is a need for further study of the health hazards of nuclear development activities on or near Indian reservations. Numerous studies have been conducted concerning abandoned uranium mill tailings piles located on Indian land and remedial action begun where appropriate. While a concern, the risk of cancer developing from background radiation in uranium mining or milling occupations is extremely small and other health problems exist on Indian land which pose considerably more risk to the Indian population than radiation. In addition, "A Plan for Diagnosis and Prevention of Illness Related to Nuclear Resources Development on Indian Land" was developed in accordance with section 707(b) and was forwarded to Congress on June 18, 1984.

Section 704 of the bill would authorize funds for an additional four years for Arizona as a Contract Health Service Delivery Area (CHSDA) but would cover only members of Federally recognized tribes of Arizona. Because there are administrative procedures in place by which Arizona could be designated as a single CHSDA, specific legislation is not required to permit such a result. In addition, the restriction of contract health service eligibility only to members of tribes located in the Arizona CHSDA would differ from the eligibility criteria in the other CHSDAs. For this reason, the Department opposes section 704.

The Department opposes section 705 of the bill which provides a special definition of California Indian eligibility and recommends that, instead, the provisions in the current section 709 be extended but limited to those individuals who were members of federally recognized tribes in California at the time their federal recognition was terminated. We recognize that there are unique problems in California, but we do not believe these problems center around the definition of eligibility for IHS programs.

The Department does not oppose the designation of a single contract health service delivery area (CHSDA) for California as provided in section 706 of the bill, but believes it should include only counties that are currently in either a CHSDA or an IHS service area. The bill, as written, would add eleven counties to the IHS service area and increase the potential service population, based on projections of census figures, by almost 28,000 people.

The Department opposes section 707 of the bill which gives non-tribal Indians in California the right to opt out of a P.L. 93-638 contract if 51% of the affected adults so desire. We believe this could add further devisiveness to the California situation and undermine P.L. 93-638. Without being able to serve the total service population, a tribe might not be able to contract under P.L. 93-638 because of the indivisibility of the function or the need for a population sufficiently large so as to justify the contract. In addition, we are very concerned that this would lead to increased litigation because of the many ambiguous aspects of the proposal, e.g., how do you determine whether an organization represents 51% of the non-tribal Indians, and that the required percentage of adult non-tribal Indians does, in fact, object to the proposal. We believe the provision would permit any group claiming to represent 51% of non-tribal Indians to block many P.L. 93-638 contracts in California. The IHS could, of course, contract with a P.L. 93-638 contractor to serve non-tribal Indians under the Buy Indian Act but this would represent a virtual duplication of administrative effort and a waste of resources.

The Department also opposes Section 708 of the bill which would retroactively prohibit the removal of National Health Service Corps (NHSC) members from IHS and P.L. 93-638 programs unless it is ensured that there would be no reduction in services. This cannot be accomplished retroactively and would be counter to any system aimed at ranking needs and directing resources to wherever the greatest need exists.

The Department suggests the following conditions be added to the section 709 proposal which would authorize IHS to provide medical care in its facilities to various classes of people who are not otherwise eligible for IHS services: (1) The Department supports opening facilities to the general public only at remote facilities and only if the State or local governments involved agree to cover the cost of care provided to the non-Indian medically indigent; and (2) any monies collected by the IHS for the care and treatment of patients, both beneficiaries and non-beneficiaries, as well as money recovered through subrogation of patient claims, including money recovered under the Federal Medical Care Recovery Act (42 U.S.C. 2641-53), for care and treatment paid for or provided by the IHS should reimburse the account of the IHS and should remain available until expended.

Finally, we believe that multi-tribal service areas that have opened IHS facilities to the non-Indian community based on the concurrence of all affected tribes should not be closed to the non-Indian community unless at least half the affected tribes revoke their concurrence.

The proposed new Section 714 would prohibit the IHS from putting any restriction on a contractor's use of program income including lobbying and litigation against the Federal government. The IHS frequently does not off-set a contractor's program income when determining the funding level. This waiver of normal Departmental policy is granted in exchange for the Contractor's agreement that it will use program income only for furtherance of the contract's purpose. Should section 714 become law, this waiver policy would have to be reviewed with the aim of assuring the maximum amount of health care for the funds available. We do not believe the proposed section 714 is in the best interest of either the Federal government or the

Indian people as it will result in a decrease in the total resources used by contractors for health care. Therefore we oppose it.

Reduction of Indian infant mortality has and continues to be of the highest priority for the IHS and the Department as demonstrated by the fact that the Indian infant mortality rate in 1980-82 is 11.9—equal to the U.S. All Races rate for 1981. While we support the intent of the proposed new section 715, to lower Indian infant and maternal mortality to a rate no greater than that of the general population, we do not support the mechanism proposed. Indian infant mortality for the neonatal period (up to 28 days after birth) is actually lower than for the general population. However, after this period, when the child has left the hospital and returns to the home, the Indian infant mortality rate rises above that of the general population. The ability to affect the rate during this latter period requires a much more complex intervention approach involving not only health care but also environmental, economic and cultural influences. The IHS should not be given the sole responsibility for ameliorating a problem which has considerable non-health aspects.

Because of these complexities, the Department does not believe that a specific five year program would be the most effective use of scarce resources. Instead, the Department recommends continued support of ongoing efforts to reduce infant morbidity as well as mortality.

The maternal mortality rate for American Indians and Alaska Natives residing in the Reservation States for 1980-82 was 7.5 per 100,000 live births. This was lower than the U.S. All Races rate for 1981 of 8.5. There have been relatively few reported Indian maternal deaths in the Reservation States over the past decade, i.e., ranging from one to four deaths per year.

The Department supports the intent of the proposed new section 716, Reduction and Control of Hepatitis-B in Alaska, however, we already have sufficient authority to accomplish all of these objectives and do not believe section 716 is necessary.

The proposed Section 717 would have the practical effect of enlarging the contract health service delivery area for the Turtle Mountain Band of Chippewa Indians to include the entire States of Montana and North Dakota. We see no justification for such a deviation from the "on or near" a reservation criteria applicable to other tribes.

The proposed new Section 718 calls for the Secretary to prepare a study on the health care needs of Native Hawaiians and other Native Pacific Islanders. It is our understanding that the IHS is not expected to conduct the study.

This concludes my opening statement. We will be glad to answer any questions you may have.

Senator ANDREWS. The other members of the committee may have questions for the record. I have several questions for the record, and Senator Melcher may, as well.

[Subsequently, the following additional questions were submitted to the Department of Health and Human Services and appear with the Agency's responses. Text resumes on p. 154.]

Department of Health and Human Services Responses to Questions Raised by the Senate Select Committee on Indian Affairs Subsequent to the March 6, 1985 hearing on S. 277, A Bill to Reauthorize and Amend the Indian Health Care Improvement Act.

1. QUESTION: In the prepared statement of Dr. Robert Graham, representing the Department of Health and Human Services, there is an allusion to confusion arising from the President's veto of a bill similar to S. 277, indicating that the President objected to a provision in S. 2166 on the grounds that it made certain Indians ineligible for certain state and locally provided health care benefits. In the interest of dispelling such confusion, the Committee wishes to make clear, for the record, that nothing in section 204 (the provision to which the President's veto message refers) of S. 2166 declares or even implies that any Indian is to be ineligible for any state or locally provided health care benefit. Rather, section 204 is intended to apply only to the criteria to be applied by the Indian Health Service in determining the eligibility of an Indian person for the services provided by the Indian Health Service.

   ANSWER: We are not aware of any confusion surrounding either the Department's opposition to Section 204 of S. 2166, Demonstration Program Regarding Eligibility of Certain Indians for Medical and Health Services, or the President's veto of S. 2166 based in part on section 204. Before passage of S. 2166, Department staff met with Congressional staff to express the Department's concern and eventually provided a written explanation, a copy of which is at attachment A.

   The President's veto message is also unequivocal, clearly stating that the provision "would have the effect of making Indians residing in Montana ineligible for certain benefits of State and locally supported health programs until and unless the availability of such benefits from the Indian Health Service (IHS) has been exhausted".

   The Department is gratified that the Committee did not intend to make any Indians ineligible for any state or local program but the fact remains that this would have been the effect of the provision. If the IHS is required to ignore an individual's eligibility for other programs and those same programs exclude from eligibility anyone with access to other resources (in this case IHS) the net result is to disenfranchise such individuals.

2. QUESTION: In the Department's written testimony, it is asserted that most of the provisions of S. 2166 duplicate existing authority. Please provide the Committee with a list of the provisions in S. 277 which the Department believes would duplicate existing authorities and in each instance, indicate the authority that is being duplicated.

ANSWER: The vast majority of programs administered by the IHS are based on the Snyder Act. The Indian Health Care Improvement Act, P.L. 94-437, for the most part provided program emphasis and not new authorities. Assuming continued appropriation of funds under the Snyder Act, the IHS could continue with most P.L. 94-437 programs. There are also, however, a number of authorities or programs in P.L. 94-437 which are not duplicative of Snyder Act programs and for which P.L. 94-437 is essential. Several of these programs are, in addition, authorized by P.L. 94-437 to serve a wider clientele than would otherwise be permitted under the Snyder Act alone. These programs and authorities follow:

Section 102 - Health Professions Recruitment Program for Indians;

Section 103 - Health Professions Preparatory Scholarship Program for Indians;

Section 104 - Health Professions Scholarship Program (i.e., Indian Health Scholarship, a component of the National Health Service Scholarship Program, now section 338G of the Public Health Service Act);

Section 105 - Indian Health Service Extern Programs;

Section 201(c)(5) - Alcoholism. Alcoholism services can be provided to Federally recognized Indians under the Snyder Act but services are extended to terminated and State recognized Indians by operation of P.L. 94-437;

Section 201(d) - Research;

Section 303 - Use of "Buy Indian" Authority for construction;

Section 404 - Grants to and Contracts with Tribal Organizations for Medicare/Medicaid access;

Title V - Health Service for Urban Indians. Specific urban Indian communities were funded by Congress under Synder Act authority before passage of P.L. 94-437, but services are extended to territorial and State recognized Indians by operation of P.L. 94-437 lapsed; and

Section 704 - Leases with Indians Tribes. The status of this authority would be called into question if P.L. 94-437 lapsed.

3. QUESTION: In the Department's written statement, it is stated that S. 2166 would have increased IHS responsibility for services that are only peripherally related to the primary mission of the Indian Health Service. Please indicate which provisions of S. 277 the Department perceives to be only peripherally related to the primary mission of the Indian Health Service.

ANSWER: The first priority of the IHS is to provide clinical services to Indian people on or near reservations. The President's budget reflects this priority. The prime example of a program in S. 277 that is not included in the budget priorities is Title V, Urban Indian Health Services. Other aspects of S.277 would divert funds appropriated for services to the development of a large number of reports, studies, guidelines, and regulations. Attachment B lists 29 such requirements contained in S. 277. Though the Department does not necessarily oppose all those listed, the overall effect is to require an excessive amount of limited resources to be committed to the listed activities.

4. QUESTION: Many of the authorization levels contained in S. 2166 were based on information supplied to the Committee by the Department, in response to Committee requests for estimates of the amount of funds that would be necessary to effectively carry out the objectives for each program authorized by the Indian Health Care Improvement Act. The written statement of the Department asserts that the authorization levels contained in S. 2166 are excessive. Please indicate to the Committee which sections of S. 277 that establish authorization levels, the Department perceives to be excessive, and for each such section, provide the Committee with authorization levels that Department believes are necessary for the effective operation of the relevant program and which would not be excessive.

ANSWER: The statement refers to any proposed authorization level that is greater than that contained in the President's budget. Examples of these differences are:

	FY 1986 (in millions)	
	S. 277	President's Budget
Title I - Manpower	$12.650	$6.499
Catastrophic Fund	$12.000	None

5. QUESTION: In the Department's prepared testimony, it is stated, "We recognize that there are unique problems in California, but we do not believe those problems center around the definition of eligibility for IHS programs nor that it would be wise to attempt to correct a localized historical problem in legislation aimed at a nationwide program." Please describe the localized historical problem to which the testimony refers and what effort the Department is undertaking or plans to pursue in resolving the problem.

ANSWER: The 19th Century treaties negotiated with the California tribes were never ratified by the United States. More recently, many California tribes were terminated and later, through a series of law suits and subsequent administrative actions, re-established as Federally recognized tribes. The tribal structure for many California Indians is very weak. Though the IHS does not require that an individual be a member of a Federally recognized tribe, IHS does require that the individual be a descendant of a Federally recognized Indian and belong to and be recognized as an Indian by an Indian community serviced by IHS. Because of the historical factors listed above there is sometimes a problem of proof to establish eligibility. The Department of the Interior has the responsibility for identifying Federally recognized tribes. It is up to the individual to establish their Indian ancestry generally with the Bureau of Indian Affairs (BIA) assistance. The IHS relies on the local BIA factors in determining if an individual meets the eligibility requirements. The IHS does not believe section 705 will change the problem of proof necessary to establish eligibility.

6. QUESTION: The Department's written testimony indicates that the Department has developed a legislative proposal which the Department believes will clearly focus on the goals of Public Law 94-437. Given that committees of the Senate and House must report any legislation which may have an impact upon the fiscal year 1986 budget by May 15, 1985, when does the Department plan to submit its legislative proposal to the Congress? If the Department does not plan to submit its legislative proposal to the Congress prior to May 15, 1985, what actions does the Department propose to take to assure that the programs authorized by the Indian Health Care Improvement Act are extended through September 30, 1986?

   ANSWER: The Department submitted its proposal to the Congress on July 29, 1985.

7. QUESTION: What is the Department's rationale for proposing that the Indian Health Manpower program be extended for three years rather than four years?

   ANSWER: The Department is recommending that funds be authorized to cover only those expenses needed to complete the educational requirements of those who have received scholarship with funds already appropriated. FY 1985 appropriation will pay for new starts this fall. Only three additional years will be needed to complete the program of study of those in four year programs.

8. QUESTION: What is the Department's rational for proposing that S.277 authorize appropriations only in the amounts that may be necessary to fund students who had been funded by October 1. 1985?

   ANSWER: The Department does not propose to fund any new scholarships after this falls cycle.

9. QUESTION: The Department's written statements asserts that section 201 has excessive reporting requirements. Please provide the Committee with specific dates or a time frame that would be

acceptable to the Department for the submission of a report to the Congress on the current health service priority system of the Indian Health Service. Further, please provide the Committee with specific dates or a time frame that would be acceptable to the Department for the submission of an annual report to the Congress on the health services priority system of the Indian Health Service.

ANSWER: Section 201 requires submission of the "current health services priority system report", including the current methodology, within 60 days of passage. The result of the most recent application of this methodology can be submitted within the 60 day limit. Delays may result where the most recent application did not include recently recognized tribes and to the extent that the most recent application must be recalculated to separate tribes where the current system combines tribal populations and/or uses the population of the local Indian community without reference to their tribal affiliation. The May 16 amendments to S.277 changed the due date for submission of an annual report on the health service priority system from 30 to 60 days after submission of the President's budget. This is an improvement. We are, however, concerned that IHS will be locked into the methodology contained in the initial report as a result of subsection (g)(1).

10. QUESTION: Please provide the Committee with the Department's best estimates of the total amount of money that is required to raise all tribes to a Level II of the health resources deficiency.

ANSWER: Based on the FY 1986 assessment of the levels of resource deficiency, approximately $47 million would be required to move 121 tribes in Level III (41 - 60 percent deficient) to Level II (40 percent deficient) of the health services priority system.

11. QUESTION: Please provide the Committee with the Department's best estimates of the total amount of money that is required to raise all tribes to a Level I of health resources deficiency.

ANSWER: Based on the FY 1986 assessment of the levels of resource deficiency, approximately $197 million would be required to move 220 tribes to Level I (20 percent deficient) of the health services priority system.

12. QUESTION: In the Department's prepared statement it is indicated that Public Law 93-638 contracts are not suitable instruments for research contracts on the grounds that research contracts must be entered into with entities that already have the needed expertise to address the subject being researched. What evidence does the Department have that tribal governments or tribal organizations lack the necessary expertise to conduct research in the areas outlined in section 201(b)(1)(A) through (F)?

ANSWER: The Department's opposition was based on the provision in P.L. 93-638 which requires the Secretary to enter into a contract with a tribe when a tribe requests a contract. This is not, in the Department's view, a proper way to determine which potential contractors should obtain scarce research dollars. The Department is not opposed to P.L. 93-638 contractors competing for research funding on an equal basis with other applicants.

13. QUESTION: With regard to the proposed catastrophic health emergency fund, the Department's testimony indicates that there is no need for a separate and additional authorization because the Indian Health Service is able to shift available resources to cover these incidents. The Department's statement fails to respond to the problem that the fund is intended to address: that is the impact such shifting of resources has on the contract care budget of each Area Office. A substantial amount of testimony received by the Committee from various parts of the country indicates that the shifting of contract health care resources to respond to catastrophic emergencies depletes available contract care resources to the extent that in some IHS area offices, there are no contract care funds available at the end of the fiscal year to address life- or limb- threatening emergencies. Does the Department contend that contract care budgets of IHS area offices are never depleted before the end of the fiscal year as a result of catastrophic emergencies, or that IHS-eligible Indian patients are never denied contract care on this basis?

ANSWER: What the Department was opposing in its statement was the need for a separate and additional authorization for such a fund or any language which could be interpreted as establishing an entitlement program for catastrophic medical care. The Department believes that the President's FY 1986 budget proposal to make funds appropriated to IHS available till expended negates the need for the section 202 provisions calling for a revolving fund. This leaves only a need to isolate such funds designated as part of the Catastrophic Health Emergency Fund from P.L. 93-638. As Dr. Graham said in his statement "The Department supports in principle the efforts to rationalize and institutionalize the current IHS efforts to deal with this increasingly important problem."

14. QUESTION: In the Department's prepared testimony, it is stated that "the Department opposes the provision that would require the Secretary to waive competitive bids simply on the basis of a certification from the responsible 'Chief Medical Officer' that accessibility, quality, or continuity of care would be endangered." The implication of the Department's statement is that competitive bids should not be waived simply on the basis that the accessibility, quality, or continuity of care would be endangered. What is the Department's view as to what factors should be considered in determining whether competitive procurement requirements should be waived? Would the Department include any factors relating to the accessibility, quality, or continuity of care in determining the circumstances under which competitive procurement requirements should be waived?

ANSWER: The Department vigoriously opposes that part of section 203 which requires the Secretary to waive competitive bids on the simple certification that in the judgment of a single individual, without any recourse or review, certain conditions exist. The Department's current policies and procedures take into account and require considerations of the factors spelled out in proposed section 203. It permits multiple awards, does not require awarding to the lowest bidder, considers awards that follow the prescribed procedures to be competitive even where only one health professional submits a bid and does not require competitive bidding in certain circumstances.

These policies are however, under review in light of the recent passage of the Competition in Contracting Act (CICA) (Title VII of P.L. 98-369) and we cannot say at this time what the impact of that law will be on current policies and procedures.

15. QUESTION: The Department's statement refers to excessive reporting requirements and inappropriate administrative provisions contained in section 301 of S. 277. Please provide the Committee with specific dates or a time frame that would be acceptable to the Department for the submission of a report to the Congress on the current health facilities priorities system of the Indian Health Service. Further, please provide the Committee with specific dates or a time frame that would be acceptable to the Department for the submission of an annual report to the Congress on the health facilities priority system of the Indian Health Service.

ANSWER: Section 301 requires submission of the "current health facilities priority system", including the current methodology and the top ten priority facilities in both the inpatient and ambulatory catagories, within 60 days of passage. The methodology that is current at the time of passage can be made available as can the priority list of the top 10 hospitals and health centers. However, the requirement that could not be met within the 60 days after enactment is the determination of the costs for design, construction, equipment and staff quarters for all of the facilities on this list.

In order to provide any of the cost information we must have an approved Program Information Document (PID) for each location which takes approximately six months to develop under the present system. This time frame will be lengthened by the requirements for review and consultation that are contained in the bill. Additional time would be required for Departmental review.

Within 90 days of enactment, the IHS can submit a priority list with preliminary cost estimates for partially funded projects with approved PIDs and for those projects for which a PID is near completion. We would need 180 days after enactment to complete the requirements for all 10 hospitals and 10 ambulatory care facilities including specific costs. Subsequent updates can then be made annually as currently expressed in the bill.

16. QUESTION: The Department's statement indicates that the Department does not believe that legislation is needed to accomplish the goals of section 702 of S. 277, establishing a juvenile alcohol and drug abuse program. What efforts has the Department undertaken to initiate a juvenile alcohol and drug abuse prevention Program?

ANSWER: In April of 1984 the Secretary of Health and Human Services established a Task Force on Black & Minority Health. The Task Force consisted of six subcommittees organized around areas of concern. These task forces were charged with the responsibility of identifying factors contributing to the marked disparity of health status between the minority and majority population. Chemical dependency was identified as an area of concern and came under the purview of the Subcommittee on Chemical Abuse. Utilizing a methodology of reviewing data submitted by agencies, including IHS, for comparison of excess deaths resulting from chemical abuse and prevalence of use among all age groups, the subcommittee was able to identify four substances (alcohol, illicit drugs, inhalants, and nicotine/cigarettes) that appear to contribute significantly to the disparity in the mortality and/or morbidity rates. They also commissioned studies to survey the research findings pertaining to each population group and substance. The conclusions drawn from this study will be the basis of a set of recommendations, an action plan, and a resource allocation model for treatment and prevention of substance abuse among all age groups of the cited minorities inclusive of American Indians.

17. QUESTION: With regard to the designation of California as a contract health service delivery area, please provide the Committee with a list of the counties in the State of California that are currently in a contract health service delivery area or in an Indian Health Service delivery area.

ANSWER: Attachment C lists the 38 California counties currently included in the IHS service area broken down into 26 counties which are Contract Health Service Delivery Areas (CHSDA) and 12 counties which are included in the IHS service area as a result of past Congressional funding for certain rural California Indian communities. Designation of these 38 counties as a single CHSDA would include the total current IHS California service population of 75,074. The provision in S.277 would increase the IHS California service population by approximately 30,000.

16. QUESTION: The Department's statement asserts that the practical effect of section 717 of S. 277 is to enlarge the contract health service delivery area for the Turtle Mountain Band of Chippewa Indians to include the entire States of North Dakota and Montana. Reference to maps of both states indicates that the three counties referred to in each State constitute not more than approximately one-sixth of the geographic area of each State. Please clarify the Department's statement.

ANSWER: The Senate version, unlike the House version, of section 717 requires a population survey and, where additional members of the Turtle Mountain Band of Chippewas are found in any additional counties in North Dakota or Montana, those counties are to be added to the Tribe's CHSDA. The effect of this provision is to include on a practical basis the entire States of North Dakota and Montana since, should any tribal member move anywhere in these two states, the county of residence would become part of the CHSDA.

Section 202 also establishes a membership requirements for eligibility for contract health services which is not an IHS requirement. In addition, section 717 applies to the total tribe and not simply to the Trenton Williston group which is, as we understand it, the group requesting the change. We do not believe such a change should be taken unless it is assured that the affected tribe supports or at least is aware of the change.

Finally, most funds appropriated to IHS over the years have been for Indians "on or near reservations". CHSDA's, as established through operation of IHS regulations, are the embodiment of what is meant by "on or near reservation" but do not represent all areas where IHS has been directed by Congress to provide services to Indians under authority of the Snyder Act. Examples of Indian populations served on a basis other than residing "on or near reservations" but rather based on specific Congressional action are the programs serving the Indian populations of various urban areas, Rapid City, South Dakota and California rural areas. Since section 717 deals with an area that is not "on or near reservation" it is inappropriate to refer to it as a CHSDA.

19. QUESTION: The Minority Biomedical Research Support Program at Montana State University has developed a study on a serious implication of the Fetal Alcohol Syndrome to the health and welfare of Indian populations in Montana and Wyoming. The study suggests that the incidence of this syndrome is substantially higher among Native Americans than it is among the population of the United States as a whole. In considering offering an amendment to S. 277 to address this problem. What would the Department's position be on such an amendment?

ANSWER: The Department's position would, of course, depend upon a review of a specific proposal though we would hope that any proposal would be consistent with the current Fetal Alcohol Syndrome (FAS) / Fetal Alcohol Effect (FAE) prevention initiative and not limit services to a specific geographic area. The IHS initiative is Service wide.

While FAS is a serious and handicapping condition, it is a totally preventable birth defect. Therefore, the IHS initiative seeks to educate the public to this fact and has trained a large number of educators to conduct education programs in their respective areas. This approach is consistent with the Surgeon General's objectives for the nation which include an intent to reduce the incidence of FAS by 25% and to increase the awareness of the risk associated with drinking while pregnant to 90% of the population by 1990.

ATTACHMENT A

The Department vigorously opposes the provision in section 201 to prohibit the IHS from considering an indigent Indian's eligibility for State and local health care programs funded by real estate taxes. Although Indians are generally not denied direct care at IHS facilities on the basis of the Indian's eligibility for other program benefits, the IHS pays for care rendered to Indians in non-IHS facilities (contract care) only after all other third party sources of payment have been exhausted. This is known as the "residual resource rule," which has been in Department regulations governing the Indian health program since 1955. The rule is based upon recognition of the rights of Indians as citizens to benefits of State and local programs and the IHS need to stretch very limited IHS contract care funds for the benefit of the entire tribal service population. The IHS pays for services through its contract care program either because no IHS facility is available or if available, the facility cannot provide the needed services. State and county welfare programs have residual policies of their own excluding persons with duplicate coverage from welfare benefits. The Federal residual resource regulation precludes State and counties from viewing the IHS contract care program as duplicate coverage. However, the proposal would change that by making Indians eligible for IHS contract care regardless of the Indian's eligibility for State or county welfare benefits. Eligibility for IHS contract care would then be used by State and local programs as the basis for denying State and county benefits on the ground of duplicate coverage. The result would be reduced benefits for Indians at a time when the needs of the Indian population outstrip the resources of the IHS. The IHS would have to assume responsibility for some portion of the medical costs of those Indians who now receive all or part of their health care through State and local programs funded by real estate taxes, thus reducing the amount of IHS funded care available for the hundreds of thousands of Indians who rely solely on the IHS for their health care.

Although the proposal concerns only those State and local government programs relying upon real estate taxes, there is a danger that the proposal would be seized upon as evidence of a sense of Congress that payment by the IHS contract care program should come before any State or local benefits. We thus view this as the first link in a chain which would constrain Indians to look to the IHS as their exclusive source of health care.

The critical point here is the Indians have long been afforded Federal benefits stemming from the special relationship of the Federal Government to the Indian Tribes as well as State and local welfare benefits stemming from their rights as State citizens. The Federal responsibility to provide health services for Indians is not exclusive. It does not relieve the States and localities of their responsibility to provide Indian citizens equal access to State and local welfare benefits.

It is also crucial to point out that the IHS provided $515 million in direct services in IHS facilities during fiscal year 1983. This represents in part, services to Indians who would also be eligible for State or county assistance. To this extent, IHS direct services already relieve the States and local governments of the cost of medical care for needy Indians--costs which would otherwise be rquired to be picked up by those States and localities under their welfare laws. Thus, IHS is already sharing the responsibility with States and counties of providing medical care to needy Indian citizens.

Additionally, we question the fairness of using the tax status of Indians living on Federal reservations as a basis for relieving State and local governments of the responsibility for provision and payment of health care. Indians are not the only group of people who benefit from programs for whose support they do not pay taxes. Property owned by religious institutions is universally exempted from local property taxes. Yet, not one has suggested that employees of those institutions should not be eligible for these State and county programs. Furthermore, military personnel and their families living on military posts or non-Indians living on an Indian reservation may benefit from programs supported by real estate taxes. Most recipients of AFDC and other welfare programs do not pay State income tax, yet they receive benefits from a program usually funded from State income revenues.

In sum, this proposal would diminish the partnership which currently exists among local, State, tribal and Federal Governments to ensure that all Indians receive adequate health care. It would result in IHS having to assume responsibility for some portion of the medical expenses of those Indians who now receive all or part of their health care through State or local sources of payment, thus reducing the amount of contract care which IHS could provide for all Indians.

ATTACHMENT B

REPORTS, STUDIES, SURVEYS, AGREEMENTS, REGULATIONS REQUIREMENTS IDENTIFIED IN S. 277, THE INDIAN HEALTH CARE AMENDMENTS OF 1985

1. Promulgate guidelines for the active duty obligation of recipients of an Indian Health Scholarship. Sec. 107(b)(3)
2. Within 60 days of the enactment of this Act, submit to Congress a report on the current health services priority system. Sec. 201(c)(1)
3. Establish regulations which would allow an Indian tribe to petition the Secretary for a review of any determination of the health resources deficiency level of such tribe. Sec. 201(c)(3)
4. Submit annual reports to the Congress 30 days after the annual budget submission by the President. Such annual reports will include the health services priority system methodology. Sec. 201(d)
5. Establish regulations providing guidelines for the implementation of Sec. 202, Catastrophic Health Program. Sec. 202(b)
6. Each Tribal Specific Health Plan submitted to the Secretary shall include a comprehensive plan developed by each tribe. Sec. 204(b)
7. Submit a report to Congress, 60 days after the enactment of this Act, the report shall set forth the current health facilities priority system. Sec. 301(a)(1)
8. Establish regulations for contracting and procurement for tribal contractors to expend funds for planning, design, construction, or renovation. Sec. 301(b)(2)
9. The Secretary must submit a plan to Congress 1 year prior to the closure any existing IHS facility. Sec. 301(d)
10. Submit a report to Congress 60 days after the enactment of this Act, such report shall include the services sanitation facilities priority system. Sec. 302(c)
11. Enter into an agreement with the State agency for purposes of reimbursement of health care and services provided to Indians who are eligible for medical assistance under the State plan. Sec. 403(c)
12. Submit to the Secretary reports on a quarterly basis, those facilities participating in the demonstration program. Sec. 405(b)(3)
13. Submit an interim report to Congress at the end of FY 1988, and a final report at the end of FY 1989 on the activities carried out under the demonstration program. Sec. 405(e)

14. Conduct a study of any barriers which may exist in programs under the Social Security Act, medicare and medicaid. Sec. 406(a)

15. Submit a report to Congress 1 year after the enactment of this Act on the study conducted on medicare/medicaid. Sec. 406(b)

16. Establish regulations for selecting Urban Indian organizations to enter into contracts. Sec. 503(b)

17. Develop procedures to evaluate compliance and performance of contracts entered into by Urban Indian organizations. Sec. 505(a)

18. Submit to the Secretary, quarterly reports during which the Urban Indian organization receives or expends funds pursuant to the contract. Sec. 507(a)

19. One year after the enactment of this Act, submit to Congress a report on the assessment of the health status and health care needs of Urban Indians. Sec. 508

20. By no later than September 30, 1986, submit a report to Congress on the Management Information System. Sec. 601(a)

21. By no later than August 30, 1986, submit to Congress a plan for the implementation of the Establishment of an Indian Health Service as an agency of the PHS. Sec. 601(e)(3)(d)

22. The Secretary, HHS, shall enter into an agreement with the Secretary of the Interior and the Secretary of Education to coordinate efforts to reduce the alcohol and drug abuse among Indian juveniles. Sec. 706(a)

23. The Secretary shall enter into arrangements with the National Academy of Science, to conduct a study on the health hazards to Indian minors and Indians living on or near Indian reservations which result from the development of nuclear resources. Sec. 703(a)

24. Submit a report to Congress 18 months after the enactment of this Act, on California as a CHSDA. Sec. 711(c)(2)

25. By January 1, 1986, develop and begin implementation of a plan for a reduction of Indian infant mortality, and maternal mortality. Sec. 715(a)

26. By no later than December 31, 1987, submit a report to Congress on the Hepatitis B Program in Alaska. Sec. 716(a)(2)

27. Conduct a population survey of Indians residing in the Trenton Service Area. Sec. 717

28. Conduct a study of the physical and mental health care needs of Native Hawaiians and other Native American Pacific Islanders. Sec. 718(a)

29. Submit a report to Congress, 1 year after enactment of this Act on the health care needs of Native Hawaiians. Sec. 718(b)

ATTACHMENT C

CALIFORNIA

IHS SERVICE POPULATION - 1985

Counties (38)	CHSDA Counties (26)	Non-CHSDA Counties (12)
Alpine	174	
Amador	379	
Butte	2,278	
Calaveras	350	
Colusa	218	
Del Norte	1,505	
El Dorado	795	
Fresno (Part)	3,049	
Glenn	393	
Humboldt	6,180	
Imperial	1,510	
Inyo	1,772	
Kings		792
Lake	905	
Lasser	703	
Madera		1,173
Maripose		380
Mendocino	2,686	
Modoc	386	
Mono	368	
Nevada		534
Placer		1,263
Plumas		545
Riverside	7,912	

Counties	CHSDA Counties	Non-CHSDA Counties
San Bernadino	11,196	
San Diego (Part)	11,069	
Santa Barbara (Part)	153	
Shasta	3,007	
Sierre		44
Siskoyou		1,641
Sonoma	3,872	
Sutter		679
Tehama		718
Trinity		507
Tulare	2,706	
Tuolumne	645	
Yolo	1,293	
Yuba		1,294
TOTAL	65,504	9,570

GRAND TOTAL 75,074

Population Statistics Staff
PSB/OPEL/IHS
March 7, 1985
2532K

Senator **Andrews**. We now are pleased to hear from our colleague, Senator Pressler from South Dakota.

Senator, welcome to the committee. We are glad to hear from you.

STATEMENT OF HON. LARRY PRESSLER, A U.S. SENATOR FROM THE STATE OF SOUTH DAKOTA

Senator **Pressler**. Thank you, Mr. Chairman. I shall be very brief because I know you have many other witnesses. Let me say that I shall put part of my statement in the record and summarize.

Mr. Chairman, I want to thank you for having this hearing on this most important issue. I also want to commend you and Senator Melcher and others for your continued efforts and actions in the field of Indian health.

We have again introduced desperately needed Indian health care legislation. I would hope that this legislation can be promptly approved once again by Congress and signed into law by President Reagan.

The situation on the reservations in my home State of South Dakota is quickly reaching the crisis level. The infant mortality rate for Indians is three times higher than for non-Indians in South Dakota. For Indians under the age of 45, the death rate per 100 is 38 compared to 7 per 100 for non-Indians.

I find this data shocking. Where have we gone wrong in providing health care to the Indian populations and, more importantly, what can we do to improve health care delivery on the reservations?

I am sure many of you today read the series of articles last fall in the Washington Post. These articles dealt with the conditions on the Rosebud Indian Reservation in South Dakota. Many of the instances referred to in the Post were almost beyond belief.

One example of the deplorable situation in the hospitals was the physician called the "Belly Button Packer." This temporary doctor treated a patient suffering from sharp abdominal pains by stuffing the patient's navel with cotton and sending him home. The patient's condition did not improve and he then went to another clinic only to learn that he was suffering from a bleeding ulcer. Upon looking at the patient's medical records, it was found that he had a 5-year history of internal bleeding and an ulcer.

The list of these horror stories is endless: Doctors attempting surgery where no surgical facilities exist, drugs incorrectly prescribed, and patients fearful of being treated by temporary physicians.

I believe it is important to point out that many talented men and women work tirelessly to provide adequate health care on our reservations. They must constantly monitor the temporary health care personnel who come and go at a rapid rate on the reservations. Continued Federal dollars are needed for these individuals to provide essential medical care.

The services provided as a result of the Indian Health Care Improvement Act are invaluable. The necessary services must continue and we must also fulfill our commitment to provide quality health care to the Indian population of this country. The quantity and quality of health care on the reservations must continue to improve. I have been contacted by numerous South Dakotans, both Indian and non-Indian, who know first hand of the importance of this legislation.

Our goal must be to improve the heath care provided on the reservations to a level comparable to that enjoyed by other citizens living in more urban locations. Those living on reservations must be afforded the same right of access to quality health care as those in the rest of our country.

Too many infants and young persons are dying at an alarming rate in South Dakota. This legislation is a step in the right direction toward putting an end to this dangerous trend.

Mr. Chairman, I want to thank you again for allowing me this opportunity to testify before your committee.

Senator ANDREWS. Thank you, Senator. We appreciate that statement. It will be most helpful to us.

Thank you, Doctor, and your group. We appreciate having you here.

Our next witness is Terry Hunter, the executive director of the Association of American Indian Physicians and Dr. Joseph Jacobs.

It is good to have you here, Doctor. You may proceed with your statement.

STATEMENT OF DR. JOSEPH JACOBS, TREASURER, ASSOCIATION OF AMERICAN INDIAN PHYSICIANS, ACCOMPANIED BY TERRY HUNTER, EXECUTIVE DIRECTOR, ASSOCIATION OF AMERICAN INDIAN PHYSICIANS

Dr. JACOBS. Thank you, Senator Andrews.

My name is Dr. Joseph Jacobs. I am currently serving as the treasurer of the Association of American Indian Physicians. With me is Mr. Terry Hunter who is currently serving as the executive director of our organization.

On behalf of the membership of the association, I would like to thank the committee for the opportunity to convey our comments, recommendations, and overall support for the reauthorization of the Indian Health Care Improvement Act. In addition, I would like to express our appreciation to the committee for its steadfast efforts to maintain the many worthwhile and productive programs of the act through their careful attention and response to educational, medical, and health concerns expressed by Indian people from throughout the country.

We have submitted our testimony, and essentially what I would like to do is just summarize some of the points that we have submitted.

Senator ANDREWS. Thank you, Doctor. You may proceed. Let me say because I do not want to hold anybody up, I may well have to leave in a couple of minutes, as Senator Melcher had to do. We will have our committee staff director continue the hearing so we can make the record complete without having to ask anybody to come back. If additional Senators show up, of course, they will be conducting the hearing.

You may proceed.

Dr. JACOBS. Thank you, Senator Andrews. We do understand that commitment on time.

Senator ANDREWS. The bells go and we go.

Dr. JACOBS. Exactly.

With regard to the title I Indian health manpower, the Association of American Indian Physicians [AAIP] has long dedicated itself to increasing the number of American Indian health professionals. The glaring disparity between the number of physicians from the Indian community compared to the dominant population persists. The current ratio of 20 Indian physicians per 100,000 Indian population contrasts with recommendations from the Bureau of Health Manpower which recommends between 101 and 187 physicians per 100,000 population.

We can only document 267 American Indian physicians throughout the country. The scholarship program authorized under 437 at least allowed the ratio today to be slightly better than the ratio that existed 10 years ago.

With regard to non-Indian physician recruitment and retention, there is still a significant problem. Recently, during my informal discussions with my former colleagues at the Gallup Indian Medical Center in Gallup, NM, it was rather revealing in that they were doing some worst cast scenario projections with regard to their staffing as it relates to the budget. What was told to me during this telephone conversation is that without any physician attrition, there would be at least a $125,000 deficit during the next fiscal year. They must then plan to reduce the physician staff from 50 physicians, which on the surface sounds like a lot, to 41.

I must remind the committee that the Gallup Indian Medical Center is a secondary, quasi-tertiary care center which takes care of a lot of acutely ill Navajos.

The projections get worse with worsening budget projections. I do not really care to speculate on the possible ramifications in the future.

With regard to title VI, section 601, the Management Information System, there are some significant imperatives facing the health care industry today in the private sector as well as the Indian health care community. With regard to this imperative, Indian health care is not exempt. With the authority to bill the Medicare-Medicaid reimbursement systems by the Indian Health Service, there is increased responsibility on the Indian Health Service to have more fiscal accountability. I would dare venture to say that the Indian people, as consumers of health care, are very concerned about knowing how efficiently health care dollars are being spent.

The provision for a cost accounting system helps to fulfill this objective. From a purely management perspective, a purely management point of view of the Indian Health Service, there should be the capability of being able to at least compare the cost for a diagnostic related group between the Gallup Indian Medical Center and the Phoenix Indian Medical Center with appropriate statistical weights built into this methodology.

This is what should be periodically reported to Congress. With any computerized medical record system, however, there must be safeguards, and the verbal assurances of patient confidentiality really has to be enhanced through legislation.

With regard to section 602, elevation of the Indian Health Service to agency status, the feeling that we have is that the Health Resources and Services Administration, which as you may know has approximately 15,000 employees of which 11,000 are members of the Indian Health Service, I often wonder about the generation of policy decisions from HRSA in that to me it seems like the tail wagging the dog. I think the burden of proof of significant management improvement in the Indian Health Service, coming from HRSA input, lies on the shoulders of HRSA management.

How can people make intelligent decisions about another organization when they know extremely little about the day-to-day operations of the Indian Health Care Service?

I am open to any comments or questions that the committee may have. Thank you.

Mr. TAYLOR [presiding]. Mr. Hunter, do you have anything you would like to add?

Mr. HUNTER. Yes.

Since we have been in the business for about 10 years of trying to increase the number of Indian health professionals, we feel that title I under the act is very vital to this situation in terms of providing Indian professionals. We have some specific recommendations that I would like to share with you under title I.

Specifically under 104 of title I, dealing with the fellowships, especially for medical students, we have noticed a trend in the past few years that most of our Indian students who are in medical school are requiring at least a fifth year. Instead of going through a regular 4-year program, now they are getting into 5-year programs. We would recommend that that language be changed in the law so that they could be supported for a fifth year. We feel that this is significant because many of them go through for 4 years and use up their eligibility and then are expected to complete their education for one more year paying that cost on their own. That is a very specific recommendation that I would make to the committee to please consider.

The other recommendation that I also would make to the committee under the title I scholarships, 103 and 104, it is our understanding at this point in time that the Indian Health Service, once they review the applications, and those applications are forwarded to IHS central office, they have contracted with a group of professors here in Washington, DC, in this area, to review and to make the final determination on who is going to get the award under 104. We would make the recommendation that they have some input from an outside group who is used to dealing and working with Indian students. Often, I think, there are some factors that they do not take into consideration in terms of reviewing those scholarships. So, we would also make that recommendation to the committee.

I would also like to add that we have limited our presentation just to the title I and also to the management information systems, but we also support all the other titles, especially in regard to the CHR programs. We would defer to the NIHB testimony and also title V to the American Indian Health Care Association.

Mr. TAYLOR. I thank you for your statement.

I might say that we are running a fairly tight schedule today, and I know a number of people have airplane flights. We will probably be taking some people out of order in order to accommodate that. As a consequence of this schedule, we are going to keep our questions to a minimum. Pat, do you have any questions?

Ms. ZELL. No, thank you.

Mr. TAYLOR. Paul?

Mr. ALEXANDER. No, thank you.

Mr. TAYLOR. We thank you very much for the statement. We will certainly consider it as we move forward.

Dr. JACOBS. Thank you very much, Mr. Taylor, on behalf of the organization. Again, we appreciate the opportunity to appear before the committee.

Mr. TAYLOR. Thank you very much.

[The prepared statement follows:]

PREPARED STATEMENT OF JOSEPH J. JACOBS, M.D. TREASURER, ASSOCIATION OF AMERICAN INDIAN PHYSICIANS

I am Dr. Joseph Jacobs, a Caughnawaga Mohawk, and Treasurer of the Association of American Indian Physicians (AAIP). On behalf of the membership of the Association, I would like to thank the Committee for the opportunity to convey our comments, recommendations and overall support for the reauthorization of the Indian Health Care Improvement Act. In addition, I'd like to express our appreciation to the Committee for it's steadfast efforts to maintain the many worthwhile and productive programs of the Act, through their careful attention and response to educational, medical and health concerns expressed by Indian people from throughout the country.

AAIP is an organization of American Indian and Alaska Native physicians whose purpose finds expression in the pursuit of two collateral goals: 1) to increase the capacity of the national health care system to provide quality and comprehensive medical care to American Indians, and 2) to effectively promote and encourage the involvement of American Indians in all aspects of Indian health, especially as medical practitioners and health policy makers. To this end, AAIP has for ten years actively and tangibly assisted American Indian students who have demonstrated the desire and ability to become physicians. AAIP has worked closely with numerous medical and educational organizations, both public and private, to increase the representation of American Indians in the medical professions.

I now wish to turn your attention to several specific items of the reauthorization bill. With respect to the "Indian Health Care Amendments of 1985" the Association would like to highlight and relate our special concerns for Title I, the Indian Health Manpower Program, as well as other provisions of the Amendments.

TITLE I—INDIAN HEALTH MANPOWER

The original purpose of Title I was to increase the representation of American Indians in the major health professions of medicine and dentistry. Several programs were developed to recruit Indian students into health professions schools, and thereby increase the number of Indian health professionals available to provide medical and dental care to American Indian communities. The Association believes the reauthorization of Title I is just as important today and for the future as it was in 1976. In fact it is even more important today, in light of the recent proposal of the Administration to virtually eliminate health professions education grants in the fiscal 1986 budget. According to Office of Management and Budget documents released earlier this year, "No new budget authority is requested for clinical training of health care professionals in 1986", and in addition graduate medical education programs would be reduced by almost half due to an Administration proposal to cut indirect Medicare funds paid to teaching hospitals. A brief review of some startling statistics will help substantiate our concern.

The most current data available from the United States Bureau of Health Manpower indicates that the recommended number of physicians should range from approximately 101 to 187 physicians per 100,000 people. Based on information from the 1980 Census and data gathered by the AAIP, the ratio of Indian physicians to the American Indian/Alaska Native population is approximately 20 Indian physicians per 100,000 Indian people. To reach parity with the rest of the country there should be approximately 2,300 Indian physicians. Currently, AAIP can document the practices of only 267 Indian physicians.

It is also important to look at the trends in American Indian physician production over the past ten years. Based on information from the Association of American Medical Colleges, American Indians accounted for 134 or 0.3% of all applicants to medical schools in the United States in 1974. Of the 134 Indian applicants in that year, 64 or 48% were accepted into medical school. Since then these numbers have increased, but ever so slightly, especially in terms of the health needs of Indian people. In 1983, 161 or 0.5% of all applicants to medical school were American Indians. Seventy, or 42% of these Indian students were accepted to medical schools. The total enrollment of American Indians in medical schools has risen from 159 in 1974 to 258 in 1984. At the conclusion of the school year 1974–1975, 22 American Indians graduated from medical schools in the United States. As of 1982, this number had grown to 45. During this period there was an average of 37 American Indian medical school graduates per year. In terms of gross numbers modest progress may be observed, however in terms of percentages of American Indian applicants and acceptees to and graduates of medical school, American Indian representation has remained at or very near the 0.3% level.

In recent years, the Indian Health Service, which is the principle medical care provider for many American Indians, has experienced a drastic reduction in the number of health professionals recruited for practice in the Service. The IHS has had to increasingly rely on the scholarship payback system. The current law required recipients of scholarships to perform an active duty service payback obligation by serving in the IHS, a Title V project, or private practice. However, the number of Indian physicians participating in the service obligation payback system have not approached the number required to meet the medical needs of Indian people served by the Indian Health Service.

Several reasons may be cited to explain the modest levels of improvement over the last several years, in the development of Indian health manpower. First of all, Title I was never funded at its authorized level, and certain parts of the original language of Title I diminished the scope and effectiveness of the program. Current language contained in the Title I accords priority to Indian scholarship applicants. The language should be changed to direct the scholarship program to fund Indians exclusively. This would provide more Indians the opportunity to participate in the program and increase the pool of Indian health professionals available to provide health care to the Indian population.

A major opportunity provided by the Indian Self-Determination and Education Act (P.L. 93–638) through technical and financial support for Indian Tribes is the management and operation of their own health programs. Reserving the scholarships for Indian students only, will significantly enhance the efforts of P.L. 93–638 by providing more Indian health professionals which will help achieve the goal of self-determination.

The AAIP further believes that the proposed language in Section 107 should be changed to eliminate the private practice option from the active duty service obligation. Under the current system, scholarship recipients are obliged to perform an active duty service obligation by serving in the IHS, serving in a project under Title V or in a private practice. The private practice option has not been effective because most Indians utilize the Indian Health Service or tribal health facilities. Eliminating the private practice option, and allowing the scholarship recipient to work in the IHS or tribal program offers the best opportunity to effectively provide for the health and medical needs of Indian people.

Although the Association supports scholarship assistance to Indian students in all of the major health professions, including public health administration, we would like to see more emphasis placed on the selection of Indian students who are interested in careers in medicine and dentistry. These are areas in which critical shortages of Indian health manpower exist, and we have discovered that only a very small percentage of scholarships under what was formerly section 104, has gone to students who wish to attend medical or dental school. We realize there has been a great deal of publicity concerning the so called "oversupply' ' of physicians in this country. Nevertheless, as we have indicated in this presentation, the representation of American Indians in the medical professions is only slightly better than it was ten years ago when Indian physicians accounted for less than half of one percent of all American physicians.

ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE

The proposal to elevate the Indian Health Service within the Department of Health and Human Services has received broad support from tribes and Indian organizations from throughout the country. The AAIP wholeheartedly supports the establishment of IHS as an agency of the Public Health Service.

Because of the breadth of IHS operations and the need for more direct access to higher levels of decision making and policy development, the AAIP believes that Title VI of the proposed Amendments would be instrumental in alleviating many current problems in terms of organizational direction and flexibility and in management communications.

We hope the Committee will also recognize the favorable outcomes of the establishment of IHS as an agency of the Public Health Service on governmental/tribal relations, and the attitudes and community morale of Indian people in general.

TITLE II—HEALTH SERVICES

Under the Act, Title II extends the authority for the Secretary to expend funds for the purpose of eliminating backlogs in Indian health care services and to meet known, unmet medical, surgical, dental, optometrical and other Indian health needs. Health care service provided by IHS are part of a health benefit package available to each eligible Indian who needs those services. Reduced funding limits the benefits of this package and moreover contributes to denial of services to an eligible Indian in need. The possible negative consequences are alarming and suggest that absence of needed dollars in and of itself may determine the saving and/or quality of a life.

With the development of the National Indian Health Plan last year, unmet medical needs were identified and prioritized by tribes across the U.S. Levels of deficiencies have been determined for each tribal group with hopes that adequate funding would soon be available. This has not yet happened. However, Title II of the revised Amendments would be a significant step in the right direction. In addition, the proposed Catastrophic Health Program would also play a significant role in eliminating the high yearly liklihood that the IHS may not be able to adequately address the medical needs of its clients and patients. In the past, one or two emergencies have created severe funding shortages for the IHS. The AAIP supports this new program and hopes you will give it your full consideration.

Inadequate funding since the implementation of the Act has prevented much p rogress in the provision of medical care services to Indians. Each fiscal year appropriations are significantly less than what was authorized. Given the appropriations process, and the history of uncertain Indian health policy, it is imperative that reauthorization of monies under this section be increased.

TITLE III—FACILITIES

As indicated in the revised Amendments, the purpose of Section 301 is to improve or construct IHS hospitals, health centers, health stations and other health facilities. The need has been established by both the IHS and Tribes for additional facilities as well as expansion and renovation for a growing population. The 1980 Census indicates that the Indian population is growing at a rate of 2.9% per annum or approximately 41,000 new people a year. Many Indian people continue to receive health care in inadequate, outdated and inefficient facilities. Although progress has been realized, an unmet need clearly remains.

The intent of Section 302 is to improve or construct safe water and sanitary waste disposal facilities in new and existing Indian homes and communities. While almost every American citizen has taken for granted running water and flush toilets, many Indian communities have homes without these sanitation essentials. It is much the same in terms of uncontaminated drinking water. Many of the preventable diseases that prevail in Indian communities are linked to safe water and sanitation problems. Title III should be a high priority group of programs if the health level of Indian people is to be elevated. The urgency of this provision is basic and fundamental to health problem prevention objectives and initiatives.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

The Association recognizes the important health care delivery activities of the urban Indian health clinics. Over the last several years urban Indian health clinics have done an exceptional job in spite of many obstacles. In particular the Association supports Title V as presented in these Amendments with the specification that the authority for such projects should rest with the Snyder Act of 1921. AAIP endorses the testimony of the American Indian Health Care Association i n regard to this Title.

In closing, the AAIP would also like to enthusiastically endorse the testimony of the National Indian Health Board in regard to other programs and provisions of the Amendments that I have not specifically included in this oral testimony, including the Community Health Representative Program and the health promotion and disease prevention provisions.

I would also like to reemphasize the original intentions of the Indian Health Care Improvement Act as stated as a declaration of policy "that Congress hereby declares that it is the policy of the nation in fulfillment of its special responsibilities and legal obligations to the American Indian people to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian Health Service with all resources necessary to affect that policy". We appreciate and applaud the many efforts of the Committee to draft a bill of high quality; one that we can strongly support and recommend for reauthorization.

Mr. TAYLOR. I am going to deviate from our schedule. I know Mel Sampson has an airplane flight to catch. Mel, we welcome your testimony at this time.

STATEMENT OF MEL SAMPSON, CHAIRMAN, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Mr. SAMPSON. Thank you, Mr. Taylor. I appreciate being recognized to move up and I extend my apologies to Dr. Johnson who was scheduled next.

For the record, my name is Mel Sampson. I am the chairman of the Northwest Portland Area Indian Health Board and vice chairman of the Yakima Indian Nation. I am here to testify on behalf of the Northwest Portland Area Indian Health Board which represents 37 federally recognized tribes in the States of Washington, Oregon, and Idaho. We indeed are grateful for this opportunity, and we want to commend the committee for its concern and efforts as far as the reauthorization of the Indian Health Care Improvement Act.

I will try to summarize our statement here, having given you the full statement for the record. I will go directly to title I, the health manpower provisions of S. 277.

The Northwest Portland Area Indian Health Board fully supports the reauthorization of title I of the Indian Health Care Improvement Act. We view this program as the only reliable source of future Indian health professionals and the best way to protect against Indian health manpower shortages in the future.

We also support section 108 of this bill which would include the Community Health Representative Program under the authority of the Snyder Act. However, we ask that steps be taken to assure that the CHR Program retains its separate line item status in the Indian Health Service budget if this status could be affected by the wording of the legislation.

Under title II, the board supports the concept of the Indian Health Care Improvement Fund as a mechanism to assist all tribes to fill the gaps in the health care delivery system. We respectfully request the committee's consideration that home health care be added to the list of services to be funded under section 201(b) of this title. By caring for our tribal members in their homes, we can keep many of them out of hospitals and nursing homes. I think it is a proven fact that this is a much more acceptable method for treatment to our elders and also it is an extremely cost-effective procedure, at least in our limited experience in the Portland area.

The board also strongly supports the revival of the tribal-specific health planning process and its incorporation into Indian Health Service resource allocation methodologies. However, tribes must be provided with adequate funds in order to prepare and adequately do these plans.

It is also essential that the tribal-specific health plans be actually employed by the Indian Health Service in the calculation of resource deficiencies. The Northwest tribes contend that tribes must be given an opportunity to review the RRM data based upon unique factors or extenuating circumstances in their communities which would be addressed in the tribal-specific health plans. These modifications in the RRM data should be negotiated with the Indian Health Service area office prior to submission of the health services priority system data to headquarters, and the areas should take tribal plans and priorities into account in area planning and resource distribution. Any time they propose to amend or modify the RRM criteria, we also request and recommend that the headquarters appoint or include tribal participation in this process.

The House and the Senate bills differ in the way the Indian Health Care Improvement Fund would be allocated.

Many of the Northwest tribes are opposed to the determination of resource deficiency and allocation of these funds by service unit if the service unit contains more than one tribe. It makes little sense to develop tribal-specific health plans if individual tribal needs and priorities are to be lost in a service unit-based allocation system. The area board requests that the resource needs and health priorities of individual tribes be identified and addressed in the implementation of the Indian Health Care Improvement Fund.

Under section 201, we have some concern about the area health boards as well as minihealth boards being included in the process as contract recipients.

The board strongly supports section 202 which establishes the Indian catastrophic health emergency fund and section 203 authorizing the waiver of any requirements for competitive procurement in contracting in Indian health services.

The Health Promotion and Disease Prevention Program described in section 204 is a very high priority of our Northwest tribes. We are aware that preventable diseases now comprise a large proportion of Indian Health Service hospital and outpatient care costs.

Going on to title III, health facilities, it is common knowledge that adequate funding for facilities construction and sanitation construction are high priorities of our Northwest tribes, because we know that dollars properly spent in these areas have a huge payoff in cost-benefit and improved health status. In the Northwest, ambulatory care facilities are the backbone of the Indian Health Service program, providing culturally appropriate primary health care, combined with vital preventive programs.

Unfortunately, the ambulatory care program has received very little attention in recent years. In the Northwest, we have numerous clinics serving enormous caseloads in over crowded, outdated facilities. As an example, at Yakima, the facility there was constructed to deliver service for 18,000 outpatient visits. Currently, it serves over 38,000 patient visits per year. As is the case at Fort Hall, it was constructed for 10,000 patient visits per year and currently is serving over 28,000 patients per year.

The Indian Health Service priority ranking system, which was developed to direct clinic replacement funds to communities with the heaviest workloads, has determined that 3 of our Northwest clinics are in the top 10: Yakima being No. 1, Fort Hall, No. 3, and Puyallup, No. 6. Within the next few years, we anticipate two more facilities that will need replacement.

The board believes that the optimum health services for Indian patients can be delivered through ambulatory care clinics with the use of adequate contract health dollars for hospital care.

In the area of sanitation facilities construction, the board strongly supports the very valuable policy statement and detailed proposal outlined in S. 277. The need for sanitation facilities construction for new and renovated homes is great, but we must add, equally great is the need for sanitation projects for existing homes and communities.

Proceeding on to title IV, access to health services, the board supports the provisions in S. 277 to expand the authority of Indian Health Service tribal health programs and to collect Medicare and Medicaid reimbursements. The board recommends that the authority established under this title be amended to require the return of all third-party collections to the facility providing the service with authority for expenditures of these funds resting with the local health administrator. We further oppose the concept of these particular collected funds being used as an offset for Indian Health Service direct appropriations.

The board supports section 406, the study of barriers to participation in the Medicare and Medicaid concept and program.

Moving on to title V, the urban health programs, the Northwest Portland Area Indian Health Board supports urban health programs but is concerned about possible unanticipated effects of including this program under the Snyder Act. We have requested a legal opinion on this issue. We ask the Senate Select Committee to assure that the urban health program retains its separate line item status in the Indian Health Service budget if this status could be affected by the wording of the legislation.

Under title VI, organizational improvements, the board strongly supports the House version of this title, which would elevate the Indian Health Service to the Assistant Secretary level of the Department of Health and Human Services within 6 months of the passage of this legislation.

Under title VII, miscellaneous, we support section 703 which would require the conduct of a study on health hazards related to nuclear activities, including nuclear waste disposal.

The board opposes a provision in section 710 of the bill which would designate entire States as contract service delivery areas. We feel that the Indian Health Service regulations should be applied equitably to all tribes and recommend that a study of the Contract Health Service's on or near regulations should be undertaken.

We oppose the provision, or we are opposed to the concept of making exceptions for 638 contracts unless it applies or takes into consideration all tribes or tribal groups that are eligible for 638 contracts.

The board supports section 708 of the bill but would like to see it expanded to state that new placements of health personnel funded through the National Health Service Corps would be permitted for tribes and tribal health programs. We feel it is unfair that these programs have been excluded from consideration by the National Health Service Corps merely because they receive funding from the Indian Health Service.

In section 709 of both bills, the board's position on services to ineligible persons is that this should be left up to each tribal government.

We realize that section 201(h), which was in S. 2166 last year and was a demonstration project relating to exemption from alternative resources funded through property taxes in the State of Montana, does not at this point appear in either the House or the Senate bills this year. But in the event that it is still a concern of the Montana tribes, we recommend that it be addressed either administratively or through separate legislation in the event that it may have an impact as far as the bill being vetoed again this year.

That concludes the summary of our statement.

Mr. TAYLOR. Thank you, Mel.

I think that Ms. Zell has an observation she would like to make on one point in your testimony.

Ms. ZELL. I just wanted to respond to your concern about the expression of the congressional intent that the urban Indian health care programs be funded under the authority of the Snyder Act. It is our understanding from the Appropriations Committee that that designation will in no way affect the line-item identity of the urban Indian health care budget activity. That is, that program would maintain its distinct identity and would not be merged under another budget category with programs that are directed to serve tribal and reservation based Indian people.

Mr. SAMPSON. Then, for that kind of assurance, that would be in the record as far as the procedure that this is going to be handled. We did not get that interpretation or were not able to get an interpretation of what the process was up to this point. Thank you for the clarification.

Ms. ZELL. Thank you.

Mr. TAYLOR. Thank you, Mr. Sampson, for your very excellent testimony. We have no further questions.

Mr. SAMPSON. Thank you.

[The prepared statement follows:]

PREPARED STATEMENT OF THE NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD, SUBMITTED BY MEL SAMPSON, CHAIRMAN

The Northwest Portland Area Indian Health Board, representing the thirty-seven (37) federally-recognized tribes of Washington, Oregon and Idaho, and as delegated by the tribal governments by resolution, appreciates this opportunity to meet with you today to testify on the reauthorization of the Indian Health Care Improvement Act.

Reauthorization of the Indian Health Care Improvement Act is needed to provide direction both to the Administration and to the Congressional Appropriations Commitees as they annually work to develop budgets and policies for the Indian Health Service. It will also be a reaffirmation of the national policy proclaimed in the original PL 94-437: "In fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian Health Services with all resources necessary to effect that policy". This statement is of the greatest importance to our Northwest tribes because we view this as a commitment on the part of the U.S. Congress that the government-to-government agreements made by the United States to the Indian Nations will be honored by the United States in the coming years.

In the following paragraphs we will address each provision in the Senate Bill and, where appropriate will also mention the counterpart House legislation.

TITLE I—MANPOWER

The Northwest Portland Area Indian Health Board fully supports the reauthorization of Title I of the Indian Health Care Improvement Act. We view this program as the only reliable source of future Indian health professionals and the best way to protect against Indian health manpower shortages in the future.

We also support Section 108 of this bill which would include the Community Health Representative Program under the authority of the Snyder Act. However, we ask that steps be taken to assure that the CHR Program retains its separate line item status in the Indian Health Service budget if this status could be affected by the wording of the legislation.

TITLE II—HEALTH SERVICES

The Northwest Portland Area Indian Health Board supports the concept of the Indian Health Care Improvement Fund as a mechanism to assist all tribes to fill the gaps in health service delivery, while fulfilling the Congressional and judicial mandates to achieve equity in health services delivery among tribes across the country. However, some of the details of implementing this fund need to be carefully considered.

We respectfully request your consideration that home health care be added to the list of services to be funded under Section 201(b) of this Title. By caring for our tribal members in their homes, we can keep many of them out of hospitals and nursing homes. This is much more acceptable to our elders and will also be extremely cost-effective.

The Northwest Portland Area Indian Health Board strongly supports the revival of the tribal-specific health planning process and its incorporation into IHS resource allocation methodologies. However, tribes must be provided with adequate funds in order to prepare and update these plans. IHS staff are now telling tribes that no federal funds will be available for tribal-specific health planning. A source of funding must be spelled out in the legislation or the bill report.

It is also essential that the tribal-specific health plans be actually employed by IHS in the calculation of resource deficiency. In response to S. 2166 last year, IHS Headquarters directed that each tribal-specific health plan include resource deficiency data developed by using the IHS Resource Requirements Methodology (RRM) formula. This unmodified IHS-provided RRM data is proposed by IHS to be the sole mechanism for developing the health service priority system rankings which would determe allocations under made through the Indian Health Care Improvement Fund. Our Northwest tribes contend that tribes must be given an opportunity to review this RRM data and based upon unique factors or extenuating circumstances in their communities which would be addressed in the tribal-specific health plans. These modifications in the RRM data should be negotiated with the IHS Area Office prior to submission of the health services priroty system data to IHS Headquarters, and the Areas should take tribal plans and priorities into account in Area planning and resource distribution. Tribes should also be given a regular formal opportunity to review the RRM methodology itself and provide recommendations for change to IHS Headquarters. IHS should periodically review these recommendations and revise RRM accordingly. Any task forces appointed by IHS Headquarters to revise RRM should include tribal participation.

The House and Senate bills differ in the way the Indian Health Care Improvement Fund would be allocated. The House version would calculate resource deficiency and allocate these funds by Service Unit; the Senate bill would calculate deficiencies by tribe but would allocate resources by Service Unit, specifying that each tribe in the Service Unit would benefit.

Many of our Northwest tribes are adamantly opposed to the determination of resource deficiency and allocation of these funds by Service Unit if the Service Unit contains more than one tribe. It makes little sense to develop tribal-specific health plans if individual tribal needs and priorities are to be lost in a Service Unit-based allocation system. In addition, the levels of service deficiency are often very different among the tribes in a Service Unit. (One of our Northwest Service Units contains ten tribes). Averaging these differences would result in some very deficient tribes not qualifying for their fair share of Improvement Funds because other tribes in the Service Unit are considerably less deficient. A Service Unit posed allocation system could also result in the Improvement Funds going as much to the less deficient as to the more deficient tribes. The Northwest Portland Area Indian Health Board requests that the resource needs and health priorities of individual tribes be identified and addressed in the implementation of the Indian Health Care Improvement Fund.

Section 201(e)(f) specifies that only Indian Health Service and '638' contract recipients are to be eligible to receive IHS research funds. The Northwest Portland Area Indian Health Board is concerned that this would exclude Area and Service Unit Health Boards and recommends that these organizations be listed as potential recipients of IHS research monies.

The Board strongly supports Section 202 which establishes the Indian Catastrophic Health Emergency Fund and Section 203 authorizing the waiver of any requirements for competitive procurement in contracting in Indian health services.

The Health Promotion and Disease Prevention Program described in Section 204 is a very high priority of our Northwest tribes. We are aware that preventable diseases now comprise a large proportion of IHS hosital and outpatient care costs. Prevention of these health problems would not only be extremely cost effective but would dramatically raise the health status of our population. The proposed plan to allow the tribes a large role, through the tribal-specific health planning process is an excellent approach which will ensure the appropriateness and increase the effectiveness of these services.

TITLE III—HEALTH FACILITIES

Adequate funding for facilities construction and sanitation construction are high priorities of our Northwest tribes, because we know that dollars properly spent in these areas have a huge payoff in cost-benefit and improved health status. In the Northwest, ambulatory care facilities are the backbone of the IHS health program, providing culturally-appropriate primary health care, combined with vital preventive programs. At their best, these clinics provide personal attention to clients and their families, at each visit educating them to be healthier and more health conscious. Where adequate clinics exist in the Northwest, contract care hosital admissions have declined. The capital investments made in IHS ambulatory care facilities pay a far greater dividend in health status improvements than the much larger investments necessary for hospital construction.

Unfortunately the ambulatory care program has received very little attention in recent years. In the Northwest, we have numerous clinics serving enormous case loads in over crowded, out-dated facilities. For example, at Yakima, we have an outpatient clinic built for 18,000 patient visits per year which is now seeing over 38,000 patient visits per year. At Fort Hall, a clinic built for 10,000 patient visits per year is straining to serve over 28,000 patient visits per year. The crowded conditions and long waiting times create much patient disatisfaction and are very deterimental to staff morale. Where facilities and equipment are inadequate, our Indian patients are shunted into emergency rooms and other inappropriate high-cost settings.

The Indian Health Service priority ranking system, which was developed to direct clinic replacement funds to communities with the heaviest work-loads, has determined that three of our Northwest clinics are in the top ten IHS clinics needing replacement. Our Yakima clinic is number 1, our Fort Hall clinic is number 3, and our Puyallup clinic is number 6. Within the next few years, at least two other IHS clinics will be in dire need of replacement, and several of our tribes, which are operating health stations - centers with limited resources pieced together from various funding sources - will need full health centers.

The Northwest Portland Area Indian Health Board believes that optimum health services for Indian patients can be delivered through ambulatory care clinics with the use of contract health dollars for hospital care. In this way, theunique educational and preventive services which are available at our IHS clinics and nowhere else, can be provided to our Indian population while allowing them access to the highest quality hospital services in the community. We urge the Congress to give priority to the establishment of adequate ambulatory care clinics throughout the Indian Health Service.

In the area of sanitation facilities construction, the Northwest Portland Area Indian Health Board strongly supports the very valuable policy statement and detailed proposal outlined in S. 277. The need for sanitation facilities construction for new and renovated homes is great, but equally great is the need for sanitation projects for existing homes and communities. Funding for tribal operation and maintenance of sanitation systems is also a major problem for many of our Northwest tribes, which must be addressed if sanitation systems are to function properly and play their vital role in improving health status.

TITLE IV—ACCESS TO HEALTH SERVICE

The Northwest Portland Area Indian Health Board supports the provisions in S. 277 to expand the authority of Indian Health Service tribal health programs and to collect Medicare and Medicaid reimbursements. If services are being provided to Medicaid or Medicare-eligible Indians, then IHS and tribes should be reimbursed in order to improve service to Indian patients.

The Northwest Portland Area Indian Health Board recommends that the authority established under this Title be amended to require the return of all third-party collections to the facility providing the service with authority for expenditures of these funds resting with the local health administrator. This is a valuable and appropriate incentive for the Service Unit to collect these funds.

Additionally, we are concerned about the continued efforts by the Administration to offset IHS direct appropriations with third-party revenue collected under this provision. These Medicare and Medicaid funds are needed, as directed in the original 437 legislation, for improvement of IHS facilities in order to meet national accreditation standards. We request that the Senate Select Committee on Indian Affairs develop stronger language on the required use of these monies to give priority to equipment purchases, facility remodeling and other physical needs of the facilities, rather than on-going staffing and other uses which should be met from the Hospitals and Clinics budget activity.

The Northwest Portland Area Indian Health Board supports Section 406 the study of Barriers to participation in Medicare and Medicaid. Our Northwest tribal members are experiencing great problems with the state Medicaid Programs as well as in some areas, being unable to locate any physician who will accept payment under the Medicaid program. The inadequacy of the state Medicaid programs creates serious access and quality of care problems for our population which we would like to encourage the Congress to investigate and document.

TITLE V—URBAN HEALTH PROGRAMS

The Northwest Portland Area Indian Health Board supports urban health programs but is concerned about possible unanticipated effects of including this program under the Snyder Act. We have requested a legal opinion on this issue. We ask the Senate Select Committee to assure that the Urban Health Program retains its separate line item status in the Indian Health Service budget if this status could be affected by the wording of the legislation.

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

The Northwest Portland Area Indian Health Board supports the House version of this title, which would elevate the Indian Health Service to the Assistant Secretary level of the Department of Health and Human Services within six months of the passage of the legislation.

This change should be implemented without delay to give IHS authority to develop an appropriate management system to deliver health services to the Indian population, consistent with Indian self-determination and the government-to-government relationships between the federal government and the tribes.

TITLE VII—MISCELLANEOUS

The Board strongly supports Section 702 providing for the establishment of a Juvenile Alcohol and Drug Abuse program in IHS.

The Board also supports Section 703 which would require the conduct of a study on Health Hazards related to nuclear activities, including nuclear waste disposal; however we are concerned by reports that the National Academy of Sciences has not been objective in past studies on nuclear topics. We support the Senate version of this Section which would require that the National Academy of Sciences do the study in consultation with the Congressional Office of Technology Assessment and also recommend that the Senate Select Committee and House Interior Committee be consulted on the selection of a research team to assure that a pro-nuclear bias is not built into this study.

The Board opposes the provision in Section 710 of the bill which would designate entire states as Contract Health Service Delivery Areas. We feel that IHS regulations should be applied equitably to all tribes and recommend that a study of the CHS "on or near" regulations be undertaken.

The Board opposes the provision in Section 711(b) which makes provision for changing the '638' contracting regulations for the State of California to give non-tribal Indians to veto power over '638' contracts. Although this provision is limited geographically, we feel that it sets a bad precedent which could affect all tribes.

The Board supports Section 708 of the bill but would like to see it expanded to state that new placements of health personnel funded through the National Health Service Corps would be permitted for tribes and tribal health programs. It is unfair that these programs have been excluded from consideration by the National Health Service Corps merely because they receive funding through IHS.

In Section 709 of both bills the Board's position on "services to ineligible persons" is that this should be left up to each tribal government. We do not feel that the provision of the bill which would permit the expansion of Contract Health Services to non-Indian spouses in some tribes but not others without additional funding would be workable.

Although Section 201(h) of S. 2166, a demonstration project relating to exemption from alternative resources funded through property taxes in the state of Montana, does not appear in either the House or Senate bills this year, if this is still a concern of Montana tribes, we recommend that it be addressed either administratively or through separate legislation in order to avoid endangering the passage of S. 277.

This concludes our statement. We thank you again for the opportunity to provide this testimony. We would be happy to answer any questions and are ready to assist the Committee in any way possible in its further work on this bill.

Mr. TAYLOR. I would like to call up some other witnesses whom I know have airplane schedules to meet. I think I will bring you up as a panel. We would like Roberta Oliver, Norine Smith, and William Hobson, please.

Ms. Oliver, you are No. 1 on the list. I suggest that you control the panel and proceed as you wish.

STATEMENT OF ROBERTA OLIVER, EXECUTIVE DIRECTOR, AMERICAN INDIAN HEALTH CARE ASSOCIATION, ACCOMPANIED BY ERMA MUNDY, PHOENIX URBAN INDIAN HEALTH CARE PROGRAM; AND BERT STEEVES, DIRECTOR, WICHITA URBAN INDIAN HEALTH CARE PROGRAM

Ms. OLIVER. Thank you.

Mr. Chairman, may I introduce Erma Mundy from the Phoenix Urban Indian Health Program to my right. To my left is Bert Steeves, Director of the Wichita Urban Indian Health Program.

I would like to state very briefly before we go on to the other witnesses, I am the Director of the American Indian Health Care Association. We have been in existence for 10 years now, overseeing all of the activities and growth of the Urban Indian Health programs. I myself have been associated with the Urban Indian Health programs since 1972.

I would like to highlight that we strongly support the inclusion to base the authority for title V programs under the Snyder Act. Just to refresh our memories, back in 1972, the original Urban Indian Health programs were funded under the authority of Snyder Act by the Indian Health Service when Dr. Johnson was the Director.

To continue on, the evaluations that have occurred, in fact, twice, 1981 and 1983, clearly point to the cost-effectiveness of the Urban Indian Health Programs as well as showing that we have maximized our accessing of alternate resources. Even though we have demonstrated over and over that we have secured additional dollars out of other Federal programs as well as State and local governments, we still are unable to meet the needs that we have outlined through these evaluations.

The Hill-Burton funds have been exhausted. The hospitals which have been previously serving the indigent population in these cities no longer will or can serve these populations. The community health centers that are funded through the Bureau of Health Care Delivery and Assistance under the Public Health Service are not located in all of the Urban Indian Health Programs sites. I believe we have a gentleman from Seattle who will speak directly to that point.

I would like to make a statement in answer to Dr. Graham's recognition that the urban programs are a duplication of services. We feel that this is not a true statement. The Medicaid programs through all of the States have tightened their Federal guidelines with the result that our people are not eligible for these Federal programs. Those families that have found employment in the urban areas and have insurance, most often they have insurance that does not cover a spouse and children or they do not have major medical coverage. So, these people go without care and the health status becomes a decade behind reservation health status.

I will move on to Erma Mundy from Phoenix.

Mr. TAYLOR. Before you proceed, I would just like to observe that the prepared testimony that has been submitted to us today will appear in the record in its entirety as if it were presented here orally. We do appreciate your summarizing. Thank you.

[The prepared statement follows:]

PREPARED STATEMENT OF THE AMERICAN INDIAN HEALTH CARE ASSOCIATION, SUBMITTED BY ROBERTA OLIVER, EXECUTIVE DIRECTOR

Mr. Chairman, Members of the Committee, we appear before you today on behalf of the American Indian Health Care Association, representing 37 urban Indian health programs located in 19 states. These programs provide a range of services from direct primary health care to outreach and referral to existing health care providers. The authorization for the urban Indian programs has been Title V of the Indian Health Care Improvement Act.

The Indian Health Care Improvement Act is particularly important to the urban Indian health care programs currently authorized under Title V. Since our very survival depends on continued Congressional support for the fourth year in a row, the Administration has requested no funding for our programs. The Administration has repeatedly testified that these programs are cost effective and provide quality services, but the absence of funding reflected "budget priorities". Frankly, Mr. Chairman, we find it hard to comprehend any set of priorities that values basic health care so low. The health care provided by our programs is the most basic. For the majority of our patients, their contact with our programs is the first regular preventative health care that they have received. 37 urban Indian programs have demonstrated outstanding success in improving the overall health status of our client population, yet we must fight tooth and nail every year just to survive. There are many areas of health care delivery that cry out for our full attention. We can only look forward to a time when the urban Indian health programs will be granted the recognition they deserve as a critical part of the Indian Health Service health care delivery network.

According to the 1980 census, over 50% of the American Indian population now resides in urban communities across the nation. A large percentage of that population was moved to urban areas as a result of the massive relocation program undertaken by the Federal Government during the 1950's. This Indian population maintains strong ties with their reservations and the vast majority continue to be tribal members. No Act of Congress and no court decision has ever determined that their status as Indians terminates once they cross the reservation border. In fact, Mr. Chairman, Congress has stated that the Federal Government has a responsibility to provide health care to Indians, including urban Indians, in the Indian Health Care Improvement Act. The members of the Association take this commitment seriously and believe that the continuation of these programs is absolutely critical.

The fiscal year 1985 budget for urban Indian health programs is $9.8 million, just over 1% of the total Indian Health Service budget. With this amount, the urban Indian health programs are supposed to serve approximately 50% of the Indian population. It is obviously impossible to provide the kinds of services necessary for these people. Secretary Heckler has stated that the health care available to the American people is better than ever before and that the average expenditure per person per year was $1,635.00. In comparison, the amount available to serve 50% of the Native American population equals approximately $18.00 per person per year. It is not surprising, therefore, that the infant mortality rate for Indian people continues to be twice as high as the national average. The investment in health care for Indian people continues to be far too little.

Snyder Act

The Senate version of the Indian Health Care Improvement Act provides that the urban programs will be authorized under the Snyder Act (25 U.S.C. 13). The Association welcomes an opportunity to explore this approach to guarantee the stability and continuity of our programs. It has always been the Association's position that, even absent specific Congressional clarification, the Snyder Act provides ample authority for Indian Health Service to fund the urban programs. In fact, the first programs were established prior to the enactment of the original Indian Health Care Improvement Act under Indian Health Service's authority contained in the Snyder Act.

The obligations of the federal government have been broadly stated in the Snyder Act, (25 U.S.C. 13), which provides that funds shall be expended "for the benefit, care and assistance of the Indians throughout the United States for the following purposes: ...For relief of distress and conservation of health".*(Emphasis added). The responsibility defined by the Snyder Act was very broad. In 1971, the Assistant Solicitor for Indian Affairs, Department of the Interior, stated that

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*The Act only mentions the BIA which was, at the time (1921), responsible for the provision of health care to Indian people. The responsibility for health care was transferred to the Public Health Service in 1954. Transfer Act, 71 Stat. 370 (1954).

> (O)n its face, the ... language is abundantly clear and requires no interpretation. Literally, it authorizes the expenditure of funds for the purposes within the named program categories for the benefit of any and all Indians, of whatever degree, whether or not members of federally recognized tribes, and without regard to residence so long as they are within the United States... With language so unequivocal, it is subject to the general rule of the law that plain and unambiguous statutory language will be followed.

U.S. Department of the Interior, Office of the Solicitor, Scope of the Snyder Act, Memorandum to Commissioner of Indian Affairs from Assistant Solicitor, Division of Indian Affairs, Dec. 9, 1971.

The Supreme Court reviewed the Snyder Act's application to the BIA general assistance program in Morton v. Ruiz, 415 U.S. 199 (1974). The Indian claimants in that case resided "near" their reservation and the BIA had refused them payments on the grounds that they did not reside on the reservation. The Court found that they were entitled to benefits but declined to define the outer limits of the services authorized by the Snyder Act.

> We need not approach the issue in terms of whether Congress intended for all Indians, regardless of residence and of the degree of assimilation, to be covered by the general assistance program. We need only ascertain the intent of Congress with respect to those Indian claimants in the case before us.*

Morton v. Ruiz, 415 U.S. 199, 211 (1974). While Ruiz does state that eligibility requirements might be developed which would limit the scope of services provided to Indians, it does not reach the question of the constitutionality of such requirements. This language is dicta and not germane to the holding of the case. It is important to recognize that this case is limited to its facts. The eligible class for benefits is "at least" those Indians residing on or near the reservation who maintain close social and economic ties with the reservation community. The scope of the Snyder Act is not limited to those persons. As noted before, the most urban Indians continue to be tribal members and to maintain close ties to the reservation. Ruiz does not eliminate the argument that urban Indians are covered by the Snyder Act.

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*The Court of Appeals, finding for the claimants in the Ruiz case, based its decision on an interpretation of the Snyder Act's language requiring services to Indians "throughout the United States". 462 F.2d 818 (9th Cir. 1972). The ultimate Supreme Court decision was reached on narrower grounds as applied to the specific claimants before the Court. It did not reject the Court of Appeals findings based on the Snyder Act. The General Counsel suggests that a finding on narrow grounds "may be viewed as expressing some degree of discomfort with the breadth of the holding below". The Court stated no such thing. Absent specific language in a United States Supreme Court opinion, it is specious to attempt to enter the minds of the Justices to evaluate any "degree of discomfort". The case says what it intends to say. Legal reasoning on any other ground is highly speculative and beyond the scope of sound legal interpretation.

Given the nature of the Court's interpretation of Morton v. Ruiz, it is important for Congress to clarify the issue of the scope of the Snyder Act. A specific statement in the Act, providing for the urban Indian programs to be included under the Snyder Act will clarify any potential dispute on that subject. If the Snyder Act provisions of the Senate version of the Indian Health Care Improvement Act are adopted, the urban programs will not need to be reauthorized under the Indian Health Care Improvement Act the next time around. Given the nature of the Administration's position on urban Indian health programs, this would be a major benefit. The recognition of the urban programs status under the Snyder Act will hopefully end the debate as to whether these programs are a part of the Indian Health Service health care delivery network. This recognition will not however insure continued appropriations for urban Indian health programs. It is our hope that this and future Administrations will recognize the importance and dramatic need for these programs and provide the necessary funds to do the job that must be done.

Title V Provisions

The urban programs believe that, even with the Snyder Act authorization, the Indian Health Care Improvement Act must contain language specifying the nature of the programs. We believe that Indian Health Service needs these statutory guidelines to maintain and strengthen the existing programs. For that reason, we strongly support the additional provisions that are included in the Senate version of the Indian Health Care Improvement Act.

1) Section 503 recognizes that urban programs will provide direct health care services where necessary. A commitment to meet the needs of the urban Indian population through direct care is extremely important in those areas where other services are simply not available.

2) No program will be established in a new area until a needs assessment has been performed by IHS. Section 504 provides that IHS determine, through a contract, the extent of the Indian population in an urban center and the unmet health care needs of that population. Once that "needs assessment" has been completed, contracts can be entered into with urban Indian organizations to meet those needs. This will insure that programs are established where the need is greatest.

3) One of the arguments made against the funding for urban Indian health programs is that they duplicate existing services. Every urban Indian program has produced documentation from other community health providers stating that they do not have the resources to provide services to the Indian population. Section 503(b)(3) provides that the utilization of existing health services will be taken into account before any contract is entered into for an urban health program. Section 503(b)(4) provides that the Secretary consider the extent to which the proposed program might duplicate existing services. We feel that this is important to defuse the "alternate resources" argument and support these criteria.

4) Section 505 which provides for evaluation of the urban Indian health contracts is extremely important to our programs. Since the first programs started, we have been seeking accountability and have repeatedly urged IHS to implement a standardized reporting system. Such a system would allow programs to keep accurate statistics on patient load, services provided, infant mortality statistics, etc. These will help to give a clear picture of the health status of the urban Indian population. We suggest that IHS be directed to implement the Urban Common Reporting Requirements system (UCRR) already developed for IHS in cooperation with the urban programs. There are smaller projects that will need technical assistance to develop the capacity to comply with these requirements. We suggest that provision be made in the bill to require IHS to provide the necessary assistance. The Association strongly supports the provisions requiring the submission of quarterly reports by the urban programs which should be based on the UCRR. Inclusion of the cost of an annual private outside audit will insure accountability based on independent evaluation.

5) As a result of repeated attempts to eliminate the urban Indian health program, IHS has made no effort to plan for the future of these programs. We consistently operate from crisis to crisis, never knowing whether we will exist in the next year. Yet, we must face an ever increasing demand for our services and needs that simply cannot be met with limited resources. Section 508 which requires IHS to submit to Congress a report containing recommendations for additional programs and funding is critical to insure that the health care needs of our service population are adequately addressed. We only hope that IHS will be allowed to do an honest report; one which will truly reflect the need for services and suggest creative health care delivery programs to meet those needs. As long as the Administration

maintains its current position, continued vigilance by Congress will be required to insure an honest report.

Elevation of the Indian Health Service

The Commission has always strongly supported the elevation of the Indian Health Service to an agency of the Public Health Service as provided for in Title VI of the Senate bill. One of the major problems that has plagued Indian Health Service for many years is the lack of accessibility to departmental decision making mechanisms. Because of Indian Health Service's place in the hierarchy, various bureaucratic hurdles prevent sound policy and budget decisions from being made. People who are not familiar with the unique circumstances of the Native American population make decisions affecting the health care delivery system for every Indian in this country. Elevation of Indian Health Service would help to eliminate some of these problems by insuring direct access to the Secretary and focus departmental policy on the issues facing Indian Health Service. Such a change could only be a positive step for the future of Indian Health Service and for Indian people.

Alternate Resources

One of the Administration's arguments for failure to request funding for urban Indian programs has been the existence of "alternate resources" to provide health care to this population. The urban programs have been able to document that these "alternate resources" are extremely limited where they exist at all.

1) Unlike tribes and tribal organizations, urban Indian organizations are not eligible for direct funding under the federal block grant program.

2) Changes in state Medicaid/Medicare policies via stricter eligibility criteria, demand for co-payment, deductibles that must be met before care is reimbursed, and ceilings on reimbursement severely limit Indian participation. As a result of these changes, some of the larger projects will sustain a 30% to 40% decrease in Medicaid revenue.

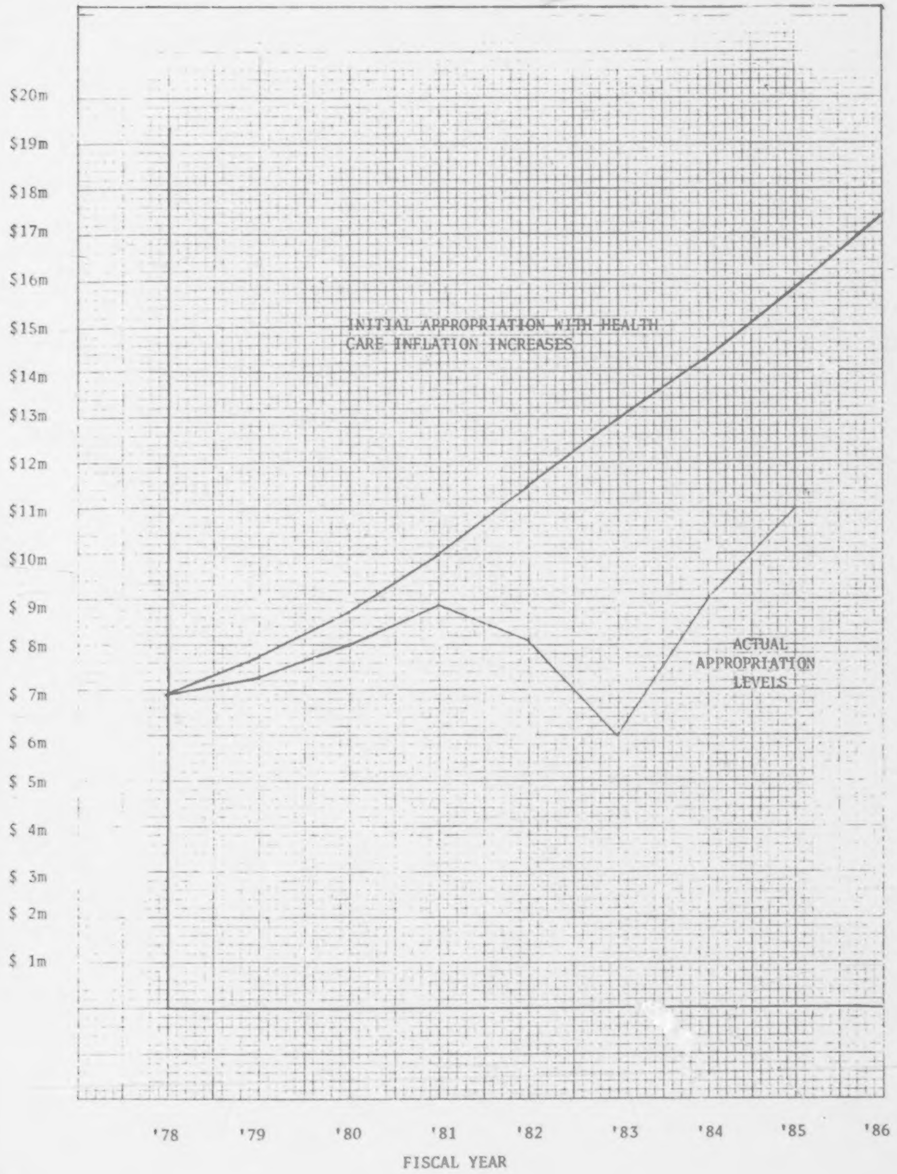
3) Many metropolitan systems refuse to provide health care to Indian patients, believing they are a federal responsibility.

4) Funds for programs which make up the community health network have been substantially reduced under the present Administration. The medically underserved population in this country is estimated at 25 million, only 5 million of whom are being served by existing community health centers.

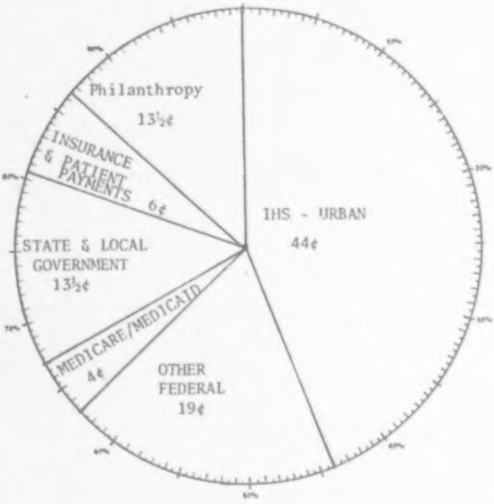
This committee is certainly more familiar with the statistics than we are. We see the actual families who make up these statistics and we know that for our clients, we are the only "safety net" that exists.

The last four years has represented a time of intense struggle for survival on the part of urban Indian health programs. Despite a strong Congressional commitment to urban programs, the Administration continues to argue that these programs are not necessary. The demand for services is increasing dramatically, certainly demonstrating a need. In Dallas, for example, the client population has increased 185.9% since 1980. The IHS dollars available during that period have only increased 10%. Looking at these kinds of statistics which are similar in the rest of the 37 programs, it is hard to understand the Administration's position that alternate resources exist to provide health care to our client population. These so-called "alternate resources" have been subjected to drastic budget cuts and simply cannot serve our patients. We have made significant strides in improving the overall health status of our patients with very few dollars. We believe that our successes should be applauded and encouraged. The reauthorization of the Indian Health Care Improvement Act is a recognition of that success and hope for the future for all Indian people. To the urban Indian health programs it represents our very survival. We can only hope that a strong reaffirmation of the Federal commitment to urban Indian health will signal to the Administration that these critical programs are here to stay.

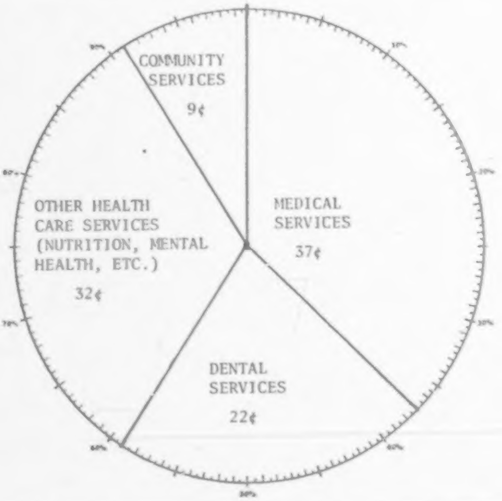
FY '78 APPROPRIATION WITH % NATIONAL HEALTH EXPENDITURE INCREASES
VS. ACTUAL URBAN INDIAN HEALTH APPROPRIATIONS



THE URBAN INDIAN HEALTH DOLLAR IN 1983
WHERE IT CAME FROM...



...AND WHERE IT WENT



Mr. TAYLOR. Ms. Mundy.

STATEMENT OF ERMA MUNDY, PHOENIX URBAN INDIAN HEALTH CARE PROGRAM

Ms. MUNDY. Thank you. I am very glad that this hearing started out talking about health promotion and disease prevention, because Indian Community Health Service in Phoenix is a health promotion program. We provide home health care, community health nursing, maternal and child health services, and WIC nutrition services.

I would also like to address the issue of alternative resources because we continually hear that there are other resources for Indian people in cities. In Arizona, in the past, most Indian people got health services at the Phoenix Indian Medical Center. While it is true they still get some services, I think that about half of the people going for services do not get them there now. For example, I know that the Phoenix Indian Medical Center does provide prenatal services for 1,200 women, but only about half of those women are able to deliver in that hospital and others are sent elsewhere. They have to find a way to pay the bill for that.

One of our burdens in Arizona is the AHCCCS Program, which is indigent health care. That stands for Arizona Health Care Cost Containment. It seems to me the big cost containment part of that program is that hardly anybody is eligible for it. So, we are finding that a lot of people are going back to the reservations to deliver their babies and also for other health care that they are not able to get in Phoenix.

Also, I would like you to know that we started our WIC Program a little less than a year ago and are now serving 850 pregnant and nursing mothers and infants and children. We find that almost all of these people had not received WIC services in the past. I think that is an indication of the unmet need for services to Indian people in the Phoenix area.

One other thing I would like to mention is that we are a licensed home health agency. We did a cost-benefit analysis of 59 patients who received home health care in fiscal year 1984 and we found that our services had a cost savings of an estimated $170,000 through this program.

We have a lot of Indian people in Arizona coming from the 20 reservations. They are very young people who are coming to Phoenix in record numbers trying to find employment and they are having a really hard time getting started and getting health care.

So, we ask that you allow us to continue to serve them through the reauthorization of title V of the Indian Health Care Improvement Act. Thank you.

[The prepared statement follows:]

PREPARED STATEMENT OF THE INDIAN COMMUNITY HEALTH SERVICE, INC., SUBMITTED BY ERMA MUNDY, EXECUTIVE DIRECTOR

Indian Community Health Service, Inc. is one of the urban health care programs funded by Title V of the Indian Health Care Improvement Act.

Our program provides home health care, community health nursing, maternal and child health services, and Women, Infant and Children (WIC) nutrition services to the Indian people living in the Phoenix metropolitan area. Our funding from

Title V of the Indian Health Care Improvement Act is $136,000. Our WIC services and Maternal and Child Health Services are funded by sources other than Title V.

Now I want to tell you why the Indian people in Phoenix need these services. First of all, this country's Indian population is young - half are age 18 and under. This is true for the Arizona tribes, and their young Indian people are rolling into Phoenix in a continuous stream seeking employment—trying to make a living. They come from tribal communities where native languages are spoken and native religions practiced. It is a new kind of life and they often have a hard time adjusting and making ends meet. Forty-eight percent of the urban Indian population in Phoenix have incomes under poverty level guide-lines.

We started our WIC nutrition program last April and are now serving 850 Indian infants, children and pregnant or nursing mothers with supplemental food vouchers and nutrition guidance. Most of these infants, children and mothers have not received WIC services although their medical history indicates need of supplemental nutrition.

We started our Healthy Mothers, Healthy Babies program in September of 1984 to provide pre-natal education classes and in-home follow-up for young Indian women who have high-risk pregnancies and do not have family support systems here in the city. Twenty-seven percent of the women we have served thus far are under age 21. 201 Indian parents attended our classes in the first four months of operation and we made 398 home visits during this time. This program affects change in the number of high-risk babies born to Indian women through three methods: making service available, public education and outreach.

We have continued with our home care program of skilled nursing services to people in their homes that allows patients to be discharged earlier from the hospital which sometimes also means no readmission to the hospital. We did a cost benefit analysis of the 59 patients who received our home health care services in FY'84. Our program saved an estimated $170,421 in hospitalization costs. In addition, the patients were happier to be at home with their families, and this speeds the recovery process.

We also provided 3,380 community health nursing services in FY'84. These are services to help people be well—it is sometimes called health promotion or disease prevention. It is helping people take responsibility for their health—learning to eat the proper foods, learning to benefit from exercise, learning hygiene methods that prevent infection and disease and learning how to manage one's ailments so they do not become debilitating—in short learning a healthful lifestyle.

All in all, we provided 5,454 services to 2,416 Indian people in FY'84. These are services that assist people to care for themselves, to be in charge of their own health and to be well. The trend of the future in medical care is toward health promotion and disease prevention. In Phoenix these services are not provided to urban Indians by Indian Health Service. An argument we often hear is "there are other services available, the same ones available to every urban resident". Unfortunately in Arizona, if a person can't afford to pay for health care they rely on AHCCCS, which is failing as an indigent health system since it leaves out the working poor—a category that includes most urban Indian people. They just don't have money for health care or health insurance premiums. I ndian Health Service and the State of Arizona continue to cut back on services to urban Indians. Our program is needed by the Indian people struggling to survive in Phoenix, and we ask to continue to serve them through Title V of the Indian Health Care Improvement Act.

Mr. TAYLOR. Mr. Steeves.

STATEMENT OF BERT STEEVES, DIRECTOR, WICHITA URBAN INDIAN HEALTH CARE PROGRAM

Mr. STEEVES. I would like to thank you for the opportunity to appear before this committee today. May name is Bert Steeves, and I am the executive director of the Indian Health Clinic in Wichita, KS. I also serve as the State coordinator for community health care for the State of Kansas.

I would like to approach the alternative care theory, and in my testimony I have brought before you testimony from the private sector from physicians in practice in Wichita who refute the alternative care theory. I have also brought to you letters of endorsement from the three major hospitals that serve a service population of 420,000 people in Sedgewick County.

This outside testimony, in addition to our testimony as administrator of the urban Indian clinic, refutes on a cost analytical basis, as well as an unduplicated service concept, the alternative theory of the administration that urban Indian health care can be provided by other sources and establish that that theoryis in fact incorrect and unsubstantiated by the cost analysis as well as the private sector testimony from the medical community; the private physicians as well as the hospitals. You will find it in my testimony as well as in the private physicians testimony. Several of those physicians are internationally known researchers in their particular area of interest. They did have the opportunity to appear before this committee in field hearings last year in Denver. Unfortunately, they are unable to be here today, but I am representing them also.

We do support S. 277 and the reauthorization of the Indian Health Care Improvement Act and those titles therein. Those physicians as well as I would be glad to work with the committee in the future in any outside expert witness testimony.

Thank you.

Mr. TAYLOR. Thank you very much.

[The prepared statement follows. Testimony resumes on p. 194.]

PREPARED STATEMENT OF THE WICHITA URBAN INDIAN HEALTH CENTER, INC.

SUBMITTED BY BERT G. STEEVES, EXECUTIVE DIRECTOR

Mr. Chairman, Senate Select Committee Members, the Wichita Urban Indian Health Center, Inc. appreciates this opportunity to appear before this distinguished Committee to substantiate the need, cost effectiveness, and quality of unduplicated care, of the Governments investment to Urban Indian Health Care Title V P..L. 94-437 amended 96-537 and in support of Reauthorization of the Indian Health Care Improvement Act of 1986, Senate Bill S. 277, January 1985.

Background

The Wichita Urban Indian Health Center, Inc. a private non-profit Indian Medical Corporation provides direct services in Medical, Dental, Mental Health Outreach/ Transportation and Food & Nutrition to over two thousand four hundred (2,400) American Indians in FY-84 representing segments of sixty-two (62) distinct and various tribes.

The National health needs for American Indians is indisputable. Indians health status continues to be far below the National level and far above the National averages of incidence rates for:

Heart disease, Diabetes, infant mortality, chronic infections, alcholism and suicide. The averages for all of the above are 2 - 6 times higher than the National average documented by the U.S. Public Health Service, Indian Health Service. The average life span of an Indian male today is 57 - 59 years of age.

The 37 urban Indian clinics are impacting on these problems. Primary preventive care versus Emergency Room and Long Term Care. The 37 urban Indian clinics provided over 650,000 services in FY-84. Over one half, 53% of the American Indian population lives in the urban setting today.

* See attached Department of Commerce Report

In 1976 when the law was passed Congress acknowledged that urban Indians were not receiving adequate or average health care due to Cultural and Economic barriers.

Alternative Care Theory

Today 1985 the Administration purports that non-reservation Indians will be eligible for health care under various alternative programs supported by Federal health block grants, and other State and local funding agencies.

This is not the case and totally ludicrous based on fact. The Block Grants aren't reaching everyone now in the States and in addition urban and rural Indian organizations are not eligible for Federal Funding under the Block Grant System. There is not a specific administrative policy that recognizes or adresses the critical health care needs of the off-reservation Indian population.

It is unrealistic to expect that the already taxed "alternative state and local resources" will be able to meet the urban and rural off-reservation Indian Health care needs.

A local survey of over 100 private physicians indicated that less than 50% were willing to accept Medicaid Recipients due to lack of adequate reimbursements and paper work. For those providers that did accept Medicaid often recipients were forced to be placed on a two to six week waiting list to be seen, due to patient overload and many providers with an unofficial priority for those with the ability to pay.

Local and County Governments, hospitals and private providers have endorsed and continue to support the urban Indian Health Clinics and have indicated they cannot supply the cost effective services that these urban Indian clinics can.

* See Hospital letters of Support attached
* See Newspaper Editorials attached
* See Charts attached

In Wichita alone it would cost the taxpayer, Federal and State Governments and Hospitals over one (1) million dollars to pick up the 2,400 patients of the Wichita Urban Indian Health Center. We receive $234,000 from Indian Health Service annually for 5 direct service departments.

Our Request

The Wichita Urban Indian Health Center, Inc. respectfully urges the Reauthorization of the Indian Health Care Improvement Act Senate Bill S. 277 for a four year period 1986 - 1989 based on the facts and their substantiation therein provided in this testimony and supported by the attached evidence including hospital letters of support.

We are requesting $12 million dollars for FY-86 based on fiscal constraint.

* See attached Charts according to the Health Care Financing Administration

Please approve the Authorization levels for Title V Health Services for urban Indians as follows:

1986	$30,552,000
1987	$32,703,000
1988	$34,996,000
1989	$37,435,000

Conclusion

As you are aware Title V urban Indian Health funds are a specific line item in the budget. These monies do not decrease the overall Indian Health Service budget and we are talking about, currently, 12 million dollars for 37 urban Indian clinics servicing, again, over 650,000 American Indian patients in FY-84.

In reality and proven there is not another alternative Resource that can provide the cost effectiveness or quality of care that the urban Indian Clinics can, substantiated.

Thank you for the privilege of addressing this Committee. I am available as a resource for you at any time.

UNITED STATES DEPARTMENT OF
COMMERCE
NEWS
WASHINGTON, D.C. 20230

BUREAU OF
THE
CENSUS

Public Information Office
(301) 763-4040

For Immediate Release

UNITED STATES AMERICAN INDIAN POPULATION PROFILED IN NEW REPORT FROM 1980 CENSUS

The 1980 census count of the nation's American Indian population was up by 72 percent compared to 1970, according to a new 1980 census report published by the Commerce Department's Census Bureau.

Figures from the 1980 census show that the number of American Indians counted on April 1, 1980, totaled 1,364,033, or 571,303 more than 10 years earlier. More than half (53 percent) of the American Indian population lived in urban areas.

Increases in the American Indian population over the decade are the result of natural increase and overall improvements in census procedures, including modified enumeration procedures on American Indian reservations and the use of self-identification to obtain the race of respondents in all areas of the country.

The report notes that the American Indian population is considerably younger than the nation's total population. Their median age was 22.9 compared with 30.0 years for the nation's total. Thirty-nine percent were under 18 years old and only 5 percent were 65 years old or older.

(more)

Of the 297,445 American Indian families in the nation, 71 percent were married-couple families. About 72 percent of "own children"--sons or daughters (including adopted and stepchildren) who were single (never married) and under 18--were living with both parents. Another 23 percent of the families were maintained by a female householder with no husband present, and 24 percent of the "own children" lived in these families.

American Indian families were comparatively large, averaging 3.87 persons. The average for all families was 3.27 persons.

In the 1980 census, 278 American Indian reservations were identified in the country. American Indian reservations are areas with boundaries established by treaty, statute, and/or executive or court order. In this report, tribal trust lands outside the boundaries of reservations (off reservation) are not included as part of the reservations.

About 25 percent of the nation's American Indian population lived on reservations. Reservations with the largest American Indian population were: Navajo, in Arizona, New Mexico, and Utah (104,968); Pine Ridge, South Dakota (11,882); Gila River, Arizona (7,067); Papago, Arizona (6,959); Fort Apache, Arizona (6,880); and Hopi, Arizona (6,601).

The 368-page report contains age, sex, marital status, and household relationship statistics for the total population, persons of Spanish origin, and racial groups, including the White; Black; American Indian, Eskimo, Aleut; and Asian and Pacific Islander populations.

Data are shown for the United States, regions, divisions, states, Standard Consolidated Statistical Areas, Standard Metropolitan Statistical Areas, urbanized areas, places of 50,000 or more inhabitants, American Indian reservations, and Alaska Native villages.

Copies of General Population Characteristics: United States Summary, PC80-1-B1 (GPO Stock No. 003-024-02747-0), are available for $6.50 each prepaid from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (Comparable housing data are being published in the HC80-1-A1, General Housing Characteristics, report.)

August 1983

St Joseph Medical Center
[illegible] CENTER FOR FAMILY HEALTH CARE

November 9, 1981

TO WHOM IT MAY CONCERN:

We would like to support the continuation and funding of the Indian Urban Health Center located at 2318 East Central in Wichita, Kansas, under United Way auspices. We understand that there may be a possibility of this organization losing its funding, and if so this would be a problem for the 2100 Indian patients served last year, and for other patients served in this population group.

St. Joseph Medical Center, through St. Mary of the Plains College, School of Nursing, has an affiliation with the Indian Health Center, and this affiliation has been of help to not only our school for the training of nurses, but has also been of help to the Center in terms of having trainees involved in their program.

The Center is cost effective; the cost is only around $37.00 per patient which is less expensive than in the private sector. These people are meeting a need for the psychiatric benefit of many Indians who could use the private sector but choose to go to the Indian Center. They are providing a service by keeping many patients away from the Emergency Rooms of the local hospitals. This takes up the slack of the burden that non-paying patients would put on the hospitals.

The Indian Health Center does not involve a duplication of service and is a needed service for the Indian community, providing basic, primary health care. Sociologically, the Indians in Wichita, a small ethnic population, need to have their own identifiable health support service, such as the Indian Health Center, as a primary service program for the screening and diagnostic discovery of patient care problems that can be either treated in the Center as a primary service initially, or referred to a specialist at one of the larger hospitals in case of a serious medical problem requiring either medical specialization, or inpatient or outpatient treatment through one of the hospital programs.

Our understanding is that this program has been in operation since June, 1980. The Center is a needed service, a community service for the Indians who seek help medically.

Sincerely,

Joseph A. Heeb

Joseph A. Heeb
Administrator

JAH:bjm

November 6, 1981

Bert Steevs
Executive Director
Wichita Urban Indian Health Center, Inc.
2318 E. Central
Wichita, Kansas 67214

Dear Mr. Steevs:

I am writing this letter in support of the Wichita Urban Indian Health Center, Inc. The Wichita Urban Indian Health Center provides quality, comprehensive health services to the Wichita Urban Indian Health population. Without this Center, most members of the Indian population would not seek or receive health care services of a preventative nature. Cultural and financial restrictions on the Indian population place them in a position where they generally seek health care only in crisis situations. In many cases the delivery of health care on this basis is inadequate and is rendered too late for positive results.

The various clinics offered through the Wichita Urban Indian Health Center provide the Indian population with an access into the health care delivery system at a time when their health problems have not reached the critical stage. These clinics offer health education, screening procedures, illness assessments and treatment programs to the Indian population. Referrals can then be made to other organizations within the health care system to provide the full range of health services necessary to maintain a healthy population.

I believe your Center offers a service to the Indian population that cannot be provided as effectively or as economically by the area hospitals or other health care agencies. I support your continued existance and congratulate you on the excellent service you are providing.

Sincerely,

Sister M Sylvia Egan
Sister M. Sylvia Egan
President and Chief Executive Officer

SMSE:pa

FRANCIS
HOSPITAL
ITA, INC.

SISTER M. SYLVIA EGAN, SSM, PRESIDENT AND CHIEF EXECUTIVE OFFICER
929 NORTH ST FRANCIS • P.O. BOX 1358 • WICHITA KANSAS 67201 • (316) 268-5102

November 10, 1981

Wichita Urban Indian Health Center
2318 East Central
Wichita, Kansas

To Whom It May Concern:

As a lifelong resident of this community and a practicing physician, it has been a pleasure to follow the development of our Wichita Urban Indian Health Center. Unfortunately, other commitments have made it impossible for me to take as great a part in the development as I might have wished.

The Urban Indian Health Center has been an integral part of the Indian's efforts to help themselves in the transition into our urban life. From what I have seen these efforts have been unpretentious and very cost effective. I feel a diminution of effort or support for this center will lead these people into the confusion of unplanned emergency room visits. As a part of an emergency room corporation at Wesley Hospital I rarely saw Indians in our emergency. This certainly speaks well of the preventive measures of the Health Center's programs considering the fair number of health problems these people have.

It is beyond my comprehension how we cannot pay attention to such a successful program. I think everything we can do to continue its function is vital to Wichita and the Indian community mutually.

Yours truly,

R. A. Nelson, M. D.

RAN/bs

State of Kansas regional perinatal care program

THE WICHITA EAGLE-BEACON Tuesday, March 13, 1984

Herman J. Christiansen, President and Publisher
Merritt Jr., Executive Editor
eorge Neavoll, Editorial Page Editor
Peter B. Ridder, General Manager
Clark Hoyt, Managing Editor

2C

Editorials/Opinion

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As We See It:

Indian Health Act Rare Success

The Senate Select Committee on Indian Affairs should listen closely to the testimony of Wichitans at a hearing in Denver Saturday on reauthorizing the Indian Health Care Improvement Act. What it will hear is a rare success story in governmental cost effectiveness that should convince them the right program already is in place.

Five local physicians who have been integrally involved with the Wichita Urban Indian Health Center, along with the center's executive director, will testify. The story they tell won't be one of government waste and inefficiency, but one of putting limited taxpayers' dollars to the best possible use. In the last fiscal year, for example, the Wichita Urban Indian Health Center provided direct services to 2,400 people from 62 different tribes. The center received $234,000 in federal money for that, or less than $100 per patient per year.

That's far less than such care would cost through welfare or Medicaid. In fact, it's estimated it would cost as much as $2.5 million locally to provide the same care, through other channels. Prior to the local Indian health center program, up to 80 percent of Indians had little choice but to seek expensive emergency room care they couldn't afford, often for conditions that could have been minimized if preventative treatment like that at the local clinic had been available.

Such remarkable cost savings are possible in part because local doctors and residency programs donate time and services. Wichita's Urban Indian Health Center, which is a separate entity from the financially beleaguered Mid-America All-Indian Center, is, in fact, one of the most successful of 37 such centers around the country. Combined, these centers serve 650,000 American Indians.

A look at the heart disease, diabetes and infant mortality rates of those particular Americans, which run from two to six times higher than the national average, is indicative of how vitally needed health care services are for them. But the Reagan administration, under the guise of cost consciousness, consistently has recommended against funding for Indian health centers, claiming block grants and existing health care agencies better can serve the needs of non-reservation Indians. But Indian agencies aren't eligible for block grants and other public health entities are sorely taxed by federal cutbacks.

Bert Steeves, executive director of the Wichita Urban Indian Health Center, is well aware of federal deficit pressures. He's right when he says, "We need to cut, but not programs that are, in fact, saving money." The Indian Health Care Improvement Act should be reauthorized and the relatively modest $12 million national budget requested to keep it working approved by Congress.

American Indian: Urban health centers vital

THE WICHITA EAGLE-BEACON Sunday, March 4, 1984

Norman J. Christiansen, President and Publisher
Davis Merritt Jr., Executive Editor
George Neavoll, Editorial Page Editor
Peter B. Ridder, General Manager
Clark Hoyt, Managing Editor

2B

Editorials/Opinion

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As We See It:

Policy Toward American Indians A Retreat from Responsibility

Former Interior Secretary James Watt attracted much criticism last year when he suggested that poverty and social problems on American Indian reservations were "an example of the failures of socialism." But the remark — however crudely expressed — was partly correct, in the sense that the federal government's paternalistic Indian policies have caused many of the tribes' problems, and that it would be in the best long-range interest of Indian nations to move toward economic and social self-determination. But this is easier said than done, and the federal government cannot simply walk away now from problems it has had a large hand in creating.

Economic development is essential if tribes are to improve conditions on the reservations, where unemployment is at 39 percent and more than a quarter of the population lives below the poverty level. With a high rate of social problems — alcoholism, infant mortality and violent crime — reservation life is generally miserable.

As the recent Eagle-Beacon series, "The New Indian Wars," points out, the government's responsibility to help the Indian nations is not just moral, but legal. Numerous court rulings have established the government's role as trustee of Indian resources and land. Unfortunately, the government's record in carrying out that role has been one of negligence, conflicting interests and almost complete failure.

Although "self-determination" has been the professed goal of federal Indian policy since the Johnson administration, the government simply has not offered Indians adequate technical guidance and financial help in developing the water, timber, rangeland and energy reserves that could boost some tribes from poverty to economic independence.

Most reservations, though, lack such natural resources, or even the most basic local economy. They lack roads, banks, government services — all the prerequisites of economic and political clout. As a result, few economic ventures get off the ground, and the federal aid that's pumped in only helps Indians maintain a subsistence economy that keeps them dependent on federal money and make-work programs.

Many Indian leaders recognize their people's future depends on establishing the foundations for economic growth, and in recent years have begun working on comprehensive programs for developing reservation businesses and services.

The Reagan administration says it wants to encourage Indian autonomy through private, competitive industries and strong tribal governments. In practice, though, the administration has moved too far, too fast. Its "encouragement" has consisted mainly of slashing aid drastically to a wide range of federal Indian programs. The long-range goal of "self-determination" has been used as an excuse for the abrogation of federal responsibility.

The Reagan budget cuts have reduced total federal spending on Indians by $1 billion — or nearly one-third of the annual Indian budget. Most importantly, they have cut programs directly promoting Indian self-sufficiency, such as legal services, job and education programs. Cuts in health programs — such as 41 urban health centers serving the more than 700,000 Indians living near cities — have seriously hurt the dramatic progress made in Indian health care.

The administration has achieved some successes — notably, tax-exempt status for tribes and $10 million in annual seed money for developing tribal resources. But the budget cuts undermine the social, economic and political base needed to make such innovations work. Tribal development will come, but through a step-by-step approach, not sink-or-swim.

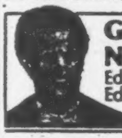
Once again, the federal government is walking away from its responsibility to the Indian nations. It is too easy to call this the "failure of socialism." It is an appalling failure of trust, of commitment.

Health Centers in Peril

Who Will Cry for Gloria Curtis?

Does anyone remember Gloria Curtis? It's not likely. No one knew her in life much, except her American Indian brothers and sisters, so there's no reason anyone would know her in death.

I heard the story of Gloria Curtis last week at the Wichita Urban Indian Health Center, one of the real health care success stories in this city — but no one knows much about it, either.



George Neavoll
Editor of the
Editorial Page

So let me tell you a little bit about both, and how their stories relate.

Gloria Curtis was the subject of a Bill Moyers' Journal television program several years back. She was a pretty young Chippewa woman with five kids who moved from the Red Lake Indian Reservation in northern Minnesota into the "Indian ghetto" of Minneapolis.

She was part of an exodus that swelled the city's Indian population fourfold over a decade's time, and she joined those Indians already there in becoming — in Bill Moyers' words — "groupless nomads in a strange new world."

There was 90 percent unemployment on the reservation, but things were even rougher in the city. In time, she and her husband separated, and she was left alone to care for her young children.

She got a job, briefly, in a nursing home where she proved invaluable, according to her supervisors, as a link between cultures for Indian patients and their white nurses.

BUT AFTER awhile, Gloria Curtis fell ill and went to a local hospital, where she had problems with the nurses and other personnel.

"They didn't ever talk nice to her," one of her Indian friends told Mr. Moyers, and one day she left, refusing ever to go back.

Finally she became so sick she had to be hospitalized again. Though she went to another institution this time, the same rude treatment awaited her, according to her friends.

It wasn't long before she died. Infectious hepatitis was listed as the cause. But her friends say that was only part of it. Equally fatal was the treatment she received in a white person's world.

The local papers carried no obituary for Gloria Curtis.

The people at the Wichita Urban Indian Health Center hope to obtain a copy of the Bill Moyers film, if they can find the money, so they can show it to others in the community as a way of explaining the desperate situation in which many urban Indians now find themselves.

Urban Indians: 'Groupless nomads in a strange new world'

I hope they find the means somehow to do it. For the situation is due to become even more desperate very shortly, if some of the folks in Washington get their way.

THE WICHITA Urban Indian Health Center started in 1975 with a one-year grant from the local Community Action Agency. Two staff members worked out of a one-room clinic. The center originally was associated with the Mid-America All-Indian Center, but no more.

Responding to the enormous need in the Indian community that soon became apparent, the center moved to a 6,000-square-foot complex at 2318 E. Central, where today 15 full-time staff members offer comprehensive health care services to 4,400 patients from 62 tribes in 16 counties, most of them from Sedgwick and Butler.

Providentially, the Junior League of Wichita has agreed to supply six volunteers to work in the center's medical intake and dental reception areas, and to provide the center $1,000 a month for the next 24 months to fund its medical prescription program.

I say "providentially," for without this critical help, the center's entire prescription program would have had to have been discontinued.

"Many of our children and elders would not have received vitally needed antibiotics," says Bert Steeves, the center's executive director. "In some cases, this would actually have been life-threatening. We cannot begin to thank the Junior League enough."

BUT THE JUNIOR League and other volunteer groups and individuals aren't always going to be around to pick up the slack when the center's important health care programs lag for lack of funds.

That's where the federal government comes in — or has, in the past, providing essential assistance to 37 urban Indian health care centers, including Wichita's, around the nation. Of the 37, the Wichita facility is one of three considered by Congress, after a study mandated by the Indian Health Care Improvement Act, as "superior."

And it has achieved that rating while saving the taxpayers $2.7 million — money that would have gone to various assistance programs — on a $233,000 Indian Health Service investment.

"It is unrealistic to expect that (such centers) will be financed with 'alternative state and local resources,'" the center's Chuck Love, until recently president of the American Indian Health Care Association, told the House Interior and Insular Affairs Committee earlier this year. ". . .(S)tates are loath to accept responsibility for health care that, in their view, is a federal responsibility."

YET THE REAGAN administration proposes to do just that, shifting the responsibility to the states when it knows full well — or should know — the states won't pick it up.

For the past three years, the administration hasn't included one dime in the federal budget for the urban Indian health centers, though Congress has put some money in each time, anyway. This fiscal year it amounts to $3 million, and Indian health professionals are hoping for at least that much next year.

"It is beyond my comprehension how we cannot pay attention to such a successful program," says Wesley Medical Center's Dr. R.A. "Jiggs" Nelson, director of the Kansas Regional Perinatal Care Program, who knows from experience what a vital function the Wichita center performs.

It's beyond my comprehension, too.

But unless we do pay attention, and do something about it, there will be more and more Gloria Curtises, wandering sick and alone until they die their needless deaths, unremembered and unwarned.

AGGREGATE NATIONAL HEALTH EXPENDITURES	ANNUAL PERCENTAGE INCREASE
1982	12.5%
1981	15.1%
1980	15.8%
1979	13.5%
1978	11.9%
1977	13.1%
1976	12.8%
1975	14.0%
1974	12.8%
1973	10.3%
1972	12.3%
1971	11.5%
1970	13.8%

LEVEL OF FUNDING - Urban Projects: 1978 $6,858,000

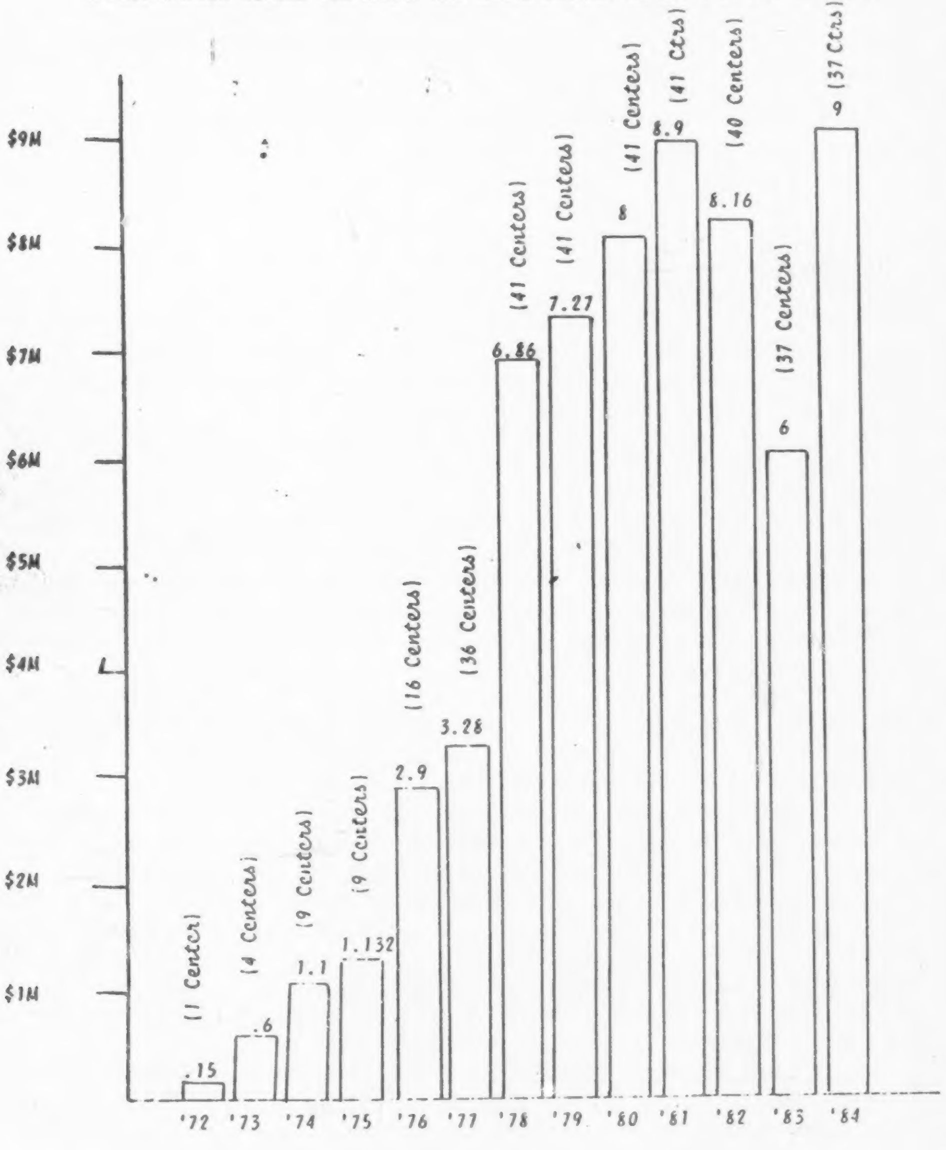
Projected Increase in Funding Based on Annual Percentage Increases for Aggregate National Health Expenditures:

1979	$6,858,000 + 11.9%	=	$7,674,102
1980	$7,674,102 + 13.5%	=	$8,710,105.8
1981	$8,710,105.8 + 15.8%	=	$10,086,302
1982	$10,086,302 + 15.1%	=	$11,609,334
1983	$11,609,334 + 12.5%	=	$13,060,501
1984	$13,060,501 + 12.8%	=	$14,732,245
1985	$14,732,245 + 12.8%	=	$16,617,973
1986	$16,617,973 + 12.8%	=	$18,745,074
1987	$18,745,074 + 12.8%	=	$21,144,443
1988	$21,144,443 + 12.8%	=	$23,850,932

**Since 1965, health care expenditures have grown at an average annual rate of 12.8%*

On 1984 *Funding Level* $9,000,000 + 12.8% = $10,152,000

APPROPRIATION LEVELS FOR URBAN AND RURAL INDIAN HEALTH SERVICE CENTERS



*In millions

Mr. TAYLOR. Mr. Hobson.

STATEMENT OF WILLIAM HOBSON, WASHINGTON STATE COORDINATOR, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, WASHINGTON, DC

Mr. HOBSON. Members of the committee, my name is William Hobson. I am a community health administrator from Seattle, WA, and I am greatly honored today to be able to speak before you in favor of the reauthorization of the Indian Health Care Improvement Act of 1976.

Today, I am speaking in my capacity as the State coordinator for the National Association of Community Health Centers, as the vice president of the Northwest Regional Primary Care Association, and the executive director of Central Seattle Community Health Centers in Seattle which is a consortium of five community health clinics serving low-income people in Seattle.

During the past 17 years, I have worked exclusively in the area of community health care. I have had an opportunity to work within the central office of the Public Health Service and 4 years in the region 10 office of the Public Health Service as a commissioned officer in the Public Health Commission Corps. For approximately the last 12 years, I have worked with private, nonprofit health care organizations in Seattle and King County providing health care to low-income people. We have a contractual relationship currently with the Seattle Indian Health Board.

My comments this morning are really directed specifically toward title V reauthorization within the Indian Health Care Improvement Act. I think that it cannot be understated that health services are the most personal and intimate services that an individual can require. For this reason, the efficiency and effectiveness of health service delivery increases in direct proportion to the sensitivity and acceptability of the health service provider and provider organization. I think if any of us were in a foreign country, there would be a great deal of anxiety if we had to go to a physician or a health treatment facility within another culture, even if there were no language difficulties. A patient's understanding and, ultimately, the patient's compliance with a given treatment regimen suffers greatly in those kinds of situations.

It has been my experience that a native American oriented community board brings a distinct flavor to the title V Health Care Programs which is not duplicated in other Health Service Programs in an urban environment. As generations of native Americans have been acclimated to reservation clinics and hospitals which serve native Americans only, there is probably more of a predisposition toward seeking an ethnic specific provider than with other ethnic groups in this country. Even if we were able to eliminate this predisposition, I feel that the Title V Programs would be sought by native Americans in order to attain the comfort factor in health services acquisition that I alluded to earlier.

The special focus of Title V Programs heightens their accessibility and acceptability thereby giving them a distinct advantage in their efforts to improve the health status of urban native Americans.

In Seattle, in King County, we have approximately 19 community health and dental clinics. We have done a market impact survey of all of those with respect to the ethnic populations that are served by the community clinic system in Seattle. We found that only 9.6 of all of the native American registered patients in the county community health clinic system are served by 18 of our community clinics. The remaining 90.4 percent of the registered native American patient population is served by one clinic, the Seattle Indian Health Board.

Because the native American population of Seattle is scattered all over the city, north and south, and in the county, in order for most of these patients to make it to the Indian Health Board, they probably have to drive by 5 to 10 other community clinics, several hospitals, and 4 or 5 different public health departments. I think that that is testimony to the fact that native Americans, even in an urban area with a number of other primary care resources, are going to seek that ethnic specific native American health care program. I only propose one potential reason for that. There may be others. I do not think anyone really has a definitive reason for that, but I think that we know that it works.

I have taken a look at some of the information from the Spokane Urban Indian Health Program, and I think it is very similar. They have essentially a population in the city of about 2,800 native Americans, and essentially better than 50 percent of that group are registered patients at the Spokane Indian Health Board.

The registered patients in 3 years for the Seattle Indian Health Board is better than 95 percent of the Seattle-based population of native Americans. I think you really cannot quibble with statistics like that. There is really a definitive showing that native Americans in urban areas will seek out these programs.

It is my understanding that there is a lot of concern or there are some ideas that the community health centers in given communities might be able to take over the role that has previously been played by title V programs. I think that there is a great fallacy in this point.

We have a situation where the community health centers have been flat-lined or frozen in funding for several consecutive years. Most of the programs around the country and particularly in Seattle have long waiting lists for service. In Seattle we can deliver only about 400 babies per year and we have 1,400 requests. The waiting time for Community Health Dental Programs for anything that is nonemergency is 9 to 13 months at any one time.

When you have a situation like that, it is absurd to feel that you can have those programs absorb the native American patients easily.

We have a situation where community health centers nationally serve about 5 million patients out of about a 20-million-person group that actually is in need of our services. I think all of you are aware of the fact that health services today are really being squeezed in many ways by new programs of reimbursement by the administration, such as the diagnostic related group reimbursement system for Medicare which very soon may be applied to Medicaid.

We have a situation where HMO's have signed up an additional 2 million subscribers in the first quarter of this year. All of those health maintenance organizations, and as we see the whole health care system moving toward that structural form, are looking for young, healthy, wealthy adults in order to make a profit. If they have lower income groups, particularly a group like the native American population with some of the worst health statistics in the country, they are not going to be able to be profitable.

As those trends continue, I think we are seeing a lot of people starting to be squeezed out of the health care provision private sector in the country. I think we are going to see a number of additional problems with that. It takes years to develop the kinds of physician-patient relationship that any of our Community Health Center Programs have around the country. If we were to close those programs, I think it would take 5 to 6 years to establish the physician-patient relationship again with some of the people that are being served, probably even longer for native Americans.

If the title V programs are defunded, I think we are going to have a very big problem with trying to improve the health status of native Americans who cannot stay on the reservations because of unemployment, and who have to come to the urban areas.

For these and other reasons that I have profiled, I urge your strong support for the reauthorization of title V.

Thank you.

Mr. TAYLOR. Thank you, Mr. Hobson.

I would just like to note that over the past 3 or 4 years, when the budget proposals for zero funding of urban health have come before us, this committee has unanimously supported continued funding for urban health. I would certainly think that the support for the title V program is pretty solid in this committee.

I have no further questions.

Ms. ZELL. Neither do I.

Mr. TAYLOR. So, we thank you all very much for your statements, and I hope you make your airplanes on time.

Ms. OLIVER. Thank you.

Mr. HOBSON. Thank you.

Mr. TAYLOR. Next, we would like to call Jake Whitecrow, Joseph Saulque, Suzan Harjo, Joseph de la Cruz, and John Lewis.

STATEMENT OF JAKE WHITECROW, EXECUTIVE DIRECTOR, NATIONAL INDIAN HEALTH BOARD, ACCOMPANIED BY JOSEPH SAULQUE, CHAIRMAN, NATIONAL INDIAN HEALTH BOARD; SUZAN SHOWN HARJO, EXECUTIVE DIRECTOR, NATIONAL CONGRESS OF AMERICAN INDIANS; JOSEPH de la CRUZ, PRESIDENT, NATIONAL CONGRESS OF AMERICAN INDIANS; JOHN LEWIS, EXECUTIVE DIRECTOR, INTERTRIBAL COUNCIL OF ARIZONA

Mr. WHITECROW. Mr. Chairman, with your indulgence, I would like to defer to Mr. Joe Saulque, chairman of the National Indian Health Board, who will make our opening remarks.

Mr. SAULQUE. Thank you, Jake.

I would like to first start by introducing everybody who is up here. As you know, this is Mr. Jake Whitecrow to my right. To his right is Mr. Joe de la Cruz, chairman of the National Congress of

American Indians. To his right is Ms. Suzan Harjo who is the executive director of the National Congress of American Indians. To her right is Mr. John Lewis who is with the Intertribal Council of Arizona.

I want to thank you for the opportunity of being able to be here to make the presentation. We appreciate the committee's efforts in reintroducing the vetoed S. 2166 in a timely manner. Hopefully, we can get it through before May 15.

The passage of the Indian Health Care Improvement Act took place in 1976. It was a turning point in the Indian health care delivery system to Indian people. It also provided a better and more direct analysis and services to the original appropriation of Indian health services finances to the Snyder Act. It also served as a blueprint to better outline the health care services to be delivered to Indian people.

Last year, during the reauthorization process, it was pleasing to see that this committee took the lead in working closely with Indian tribes and organizations to formulate a bill that would reauthorize the original act. This committee is to be commended for its major effort in putting together S. 2166. We believe that the new bill, S. 277, which we are discussing today is virtually the same as S. 2166. We reiterate our full support for the enactment of S. 277.

At this point, I would like to turn over the rest of the remaining time to the other members of the panel for specific remarks on certain parts of the proposed bill.

Mr. WHITECROW. Thank you, Mr. Chairman. We would like to, first of all, call upon the president of the National Congress of American Indians, Mr. Joe de la Cruz, for a few opening remarks.

Mr. DE LA CRUZ. Mr. Chairman, I am pleased that this committee is having an oversight hearing on this most important legislation. I can recall in 1968 pounding on a table across from a Congresswoman talking about the crucial needs of Indian people as far as health care in this country and the obligations of the United States. That was Congresswoman Julia Butler Hanson who had visited many of the Indian reservations and was wise enough to see that we needed the outpatient clinics and urban clinics way back then.

Our organizations and the tribes worked with this committee, and other committees, and the Indian Health Service to do the studies that needed to be done to show to the Congress of the United States the needs of our people in health. Over the past almost 10 years now we have been before these committees for reauthorizations as we see our health care dwindling in many areas. I commend this committee for having these oversight hearings.

I hope that we can get this reauthorization. I wish we had gotten it in 7 years to begin with when we were arguing it back in 1975. Some of the things that are happening today are very frightful as far as cuts in health care and what seems like rising needs in health for our people in the Indian community.

I want to thank you, and I certainly want to thank Jake for his cooperation in working with the National Congress of American Indians to put together the statistics that a committee like this needs.

Thank you.

Mr. WHITECROW. Now, Mr. Chairman, if I may, I would like to introduce the executive director of the National Congress of American Indians, Ms. Suzan Harjo.

Ms. HARJO. Thank you, Jake.

Jake Whitecrow and John Lewis are the cochairmen of the NCAI health committee, and we are very pleased to associate ourselves with the testimony presented here today by John Lewis as well as already having associated ourselves in joint testimony with the National Indian Health Board.

I just want to make two comments on earlier remarks. One is on a remark by Dr. Graham, and I would just point out for the record and perhaps he will read it, that a treaty does not cease being a valid treaty just because one or another party violates its terms of obligations or the spirit of it, as the good doctor stated when he said that a treaty is in effect only so long as Congress appropriates money.

The only other point I would like to make is that the United States is rich and powerful enough to be magnanimous rather than mean in setting priorities for its population of greatest need. The health status elevation is the specifically declared policy on Indian health which would lead to the inclusion rather than the exclusion of the CHR workers and the off-reservation Indians.

Thank you very much.

Mr. WHITECROW. Thank you, Suzan.

Mr. Chairman, if I may, I would like to introduce my cochairman with the Health Committee and the Health and Human Resources Committee of the National Congress of American Indians, Mr. John Lewis. He is executive director of the Intertribal Council of Arizona.

Mr. LEWIS. Thank you.

On February 8, 1985, the representatives of tribes from Arizona, Nevada, and Utah convened to discuss the Indian Health Care Improvement Act. They discussed and adopted a joint resolution. You have copies of that position, and they reflect the common issues as perceived by the tribes. The individual tribes themselves will be submitting statements on their specific concerns regarding the bill.

I would like to highlight some of the parts of that joint statement.

The tribes strongly support the community health representative program as a specific authorized program as stated in the Senate bill under title I, section 108. We feel that that is a very important approach that was taken in that particular section.

We also strongly support the health promotion and disease prevention. We see the importance of health promotion and disease prevention as a method of reducing the rising costs of medical care. We really see that the statements there are very meaningful to the approaches that need to be taken at this time.

Concerning the safe water and sanitary waste disposal facilities, title III, section 302: again, we feel that this is a very important statement that was made because it further defines the role of IHS and the tribes and expectations that each is to be responsible for. We feel that the definition in regard to operation and maintenance is a very important part of this bill.

We have one inclusion that we feel needs to be recognized. That is to include the tribes as entities in terms of recipients of the technical assistance and training and equipping. The way that we read the bill is that it looks at utility organizations. We want to make sure that that does not exclude the tribes and tribal organizations. In some areas, it is not feasible to have a utility organization, at least as our interpretation of that particular section.

Another important area that we begin to address is in the health financing area. This is an area in which much work needs to be done in the future regarding the tribes, the States, and the Federal Government. We see a good beginning in the provisions that are stated in the bill regarding Medicare and Medicaid.

We would like to see some changes made in regard to Medicare so that 100 percent of the money that is collected would be returned to the service unit. We feel this is a very important part of operations and becoming increasingly so. In the Medicaid provisions, again, we see that there needs to be 100 percent of that money going back to the areas and at least 75 percent going back to the facilities from which they were collected.

These are some changes that we feel would be more appropriate in regard to the development and the capacity of the tribes and the local service units.

We feel that the demonstration program called for in section 405 should not be limited to a few demonstrations. It should be open to all those who are prepared to enter into that area. Again, this goes back to the financing and development of the capacity of tribes and their organizations to provide for these types of services.

In the letter that was sent inviting us to participate in these hearings, there was a request to speak to section 704 which looks at Arizona as a contract service delivery area. The joint position does not reflect speaking to that particular section, but it does contain wording that is agreeable to the concerns of the Arizona tribes. It is my understanding that in the proposed provisions contained in section 704 is included the wording of the previous Indian Health Care Improvement Act which was under section 708(b) which the Arizona tribes had requested. Plus, it now revises the definition of the service population to members of federally recognized tribes of Arizona which had been another concern of the tribes.

It is my opinion that the tribes in Arizona would continue to support section 704 which includes the improvements in S. 277.

Thank you.

Mr. WHITECROW. Now, Mr. Chairman, if I may, I would like to sum up our testimony. You have received our joint testimony presented by both the National Congress of American Indians and the National Indian Health Board. This testimony has been jointly approved by both our organizations, in committee form as well as in the process now of being distributed and disseminated around the entire United States to all tribes involved.

I would also like to make one particular statement in regard to an item that we do not have included in our testimony. That applies to the so-called Montana provision. We did not broach this in our testimony inasmuch as at the time we prepared the testimony it was not considered an issue since it was not included in either of the bills, either in the Senate or in the House. However, it appears now that it may be an issue, and we would like to share our comments with you upon that particular item.

No. 1, first of all, I would like to make a fact very clear. Inasmuch as the National Indian Health Board and myself have been accused of lobbying, I would like to make this fact very clear for all concerned who might be reading this report. I am, as of this date, on leave without pay, so therefore, I am in no violation of any contractual agreement whatsoever.

Mr. TAYLOR. You may find yourself in the company of the Postmaster General or the head of the post office union.

Mr. WHITECROW. I did want to make that fact very clear today in the event any investigator may want to proceed further.

I believe I am speaking for every Indian tribe in this country. When we realize that the relationship that we, as Indian people, have with the United States is over and above the status of Indian people insofar as we being citizens of the United States. We are citizens of the United States and we are eligible for any and all beneifts and/or provisions of law that are guaranteed as a right and entitlement to every citizen of the United States.

In addition to that, Indian tribes have a very special relationship with the United States, and as such, this is an inherent right. However, we realize that the United States has never fulfilled its obligations, fulfilled its treaty responsibilities to Indian nations. Therefore, we do not expect that at this particular time in life they will change. However, we realize also it is a political world. We realize that in this past year, we faced the veto of S. 2166, and that particular bill provided a tremendous situation, stirred up our Indian people across this Nation. As a result we have Indian people who are facing serious health situations today that they should not be facing.

In the event we should get another veto, in the event the Montana provision is included in the bill, we face the potential of another veto, as we have been informed. We do not want another veto. We cannot stand another veto, but neither are we coming to this committee with our hands out, on our knees. We are holding our heads high. We are asking that this Congress and this committee recommend to the Senate of the United States that they fulfill the obligations to which this Nation has agreed.

At the same time, we also recognize the political implications that we have to stand for whatever we feel this Government will give. We cannot stand another veto, and if it is necessary, the National Congress of American Indians and the National Indian Health Board stand by to offer any assistance to this committee in determining any kind of regulatory change or considering any kind of rule change that might be applicable in order to make this situation a workable situation. Certainly, we do not want to turn off any supporter in this Congress for the fulfillment of the obligation of the United States to Indian people. So, we do humbly ask that this committee, in the event this provision should come up in the future, we would like to inform this committee we are standing by ready to work with you in any attitude that might be necessary.

I think this concludes our statement. If you have any questions for any of the panel, we stand ready to respond.

Mr. **Taylor**. I would like to thank the entire panel for the testimony. You know, the National Indian Health Board has been around for quite a while now. I think you perform an extremely important advisory and information function. You are appearing here today at our request, and that certainly is a legitimate function whether you are on the payroll or not. It is one of the purposes for your existence. So, I would like to thank you all very much for your testimony here today. I do not believe we have any questions at this time. Thank you very much.

Mr. **Whitecrow**. Thank you, sir.

[The prepared statement follows. Testimony resumes on p. 217.]

STATEMENT ON PROPOSED LEGISLATION TO REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT (P.L. 94-437)

Presented by
The National Indian Health Board
The National Congress of American Indians

Good morning, Mr. Chairman. I am Jake Whitecrow, Executive Director of the National Indian Health Board. I also serve as co-chairman of the Health Committee of the National Congress of American Indians. On behalf of the membership of the National Indian Health Board and the National Congress of American Indians, I wish to thank this Committee for the opportunity to present our views on S. 277, a bill which would reauthorize the Indian Health Care Improvement Act of 1976 (P.L. 94-437).

The National Indian Health Board, a non-profit organization based in Denver, Colorado, is composed of 12 representatives elected by their respective area health boards or inter-tribal organizations in each of the 12 IHS geographically-defined service areas. The National Congress of American Indians is the nation's oldest and largest Indian organization. Over the past several years NCAI and NIHB have worked closely with tribes, Indian health boards, inter-tribal organizations, and individual Indian health consumers to develop national positions and recommendatons related to the health and well-being of American Indians and Alaska Natives.

We deeply appreciate this Committee's efforts in reintroducing an Indian health reauthorization bill following last year's veto of

S. 2166. We are hopeful that this bill will be acted upon by Congress as expeditiously as possible. Passage of a new bill is absolutely critical to the continued provision of health services to Indian people; without such legislation the modest gains achieved in Indian health care during the past decade will be lost and we will witness a return to the deplorable health conditions that were once so prevalent in Indian communities. We urge this Committee's continued support for a swift enactment of this legislation and a reaffirmation of the national policy, proclaimed in the original Act, of "providing the highest possible health status to Indians and to provide existing Indian Health Services will all resources necessary to effect that policy."

Introduction

As determined during the congressional deliberations and oversight hearings that led to the passage of last year's Indian health bill, the health care status of Indians continues to lag far behind that of the general population. Despite progress made under P.L. 94-437, Indian infant mortality rates in many areas of the country remain significantly higher than the national average; death rates for Indian youth under 25 are nearly four times higher than among non-Indian youth; death by accident among Indians occurs at a rate two-and-a-half times greater than that of the general population; and Indians are more likely than the rest of the U.S. population to die of chronic liver disease and cirrhosis, diabetes, pneumonia, influenza, homicide, suicide, and tuberculosis. These statistics reflect the most frequently mentioned problems that lead to poor health among American Indians and Alaska Natives, including poor sanitary conditions and water supplies, poor nutrition, alcoholism, and lack of proper health education and health promotion services.

In response to these and other health problems, many of which were raised repeatedly by tribes, Indian organizations, and individual Indian health consumers during congressional field hearings two years ago, Congress mandated the continuation of programs established under the original Act (e.g., health scholarships, health services, urban Indian health services) in last year's passage of S. 2166. Congress also called for the creation of several innovative new health initiatives to further improve existing Indian health programs, including an expansion of health services responsibilities to provide for accident prevention, emergency medical services, and the Community Health Representative program; a catastrophic health emergency fund to deal with medical disasters and catastrophic illness in Indian communities; forceful new requirements calling for the provision of safe water supply, sanitary sewage and solid waste disposal systems in Indian homes and communities; inoculation and screening services to halt the hepatitis B epidemic among Alaska Natives; a creative new approach aimed at preventing alcohol and drug abuse among Indian youth; and a study of nuclear health hazards on or near Indian reservations.

In addition, and again in response to the expressed concerns of the Indian community, Congress approved amendments designed to strengthen tribal involvement in the Indian health care program. These provisions represent a bold commitment to the policy of Indian Self Determinaton, requiring that tribes have an active, vital role in health services planning, resource allocation, health facilities planning and construction, and other areas of the Indian health care delivery system.

If properly implemented, these amendments will enable tribes to take part in a meaningful working partnership with the Indian Health Service for the purpose of raising the health care status of Native Americans to a level at least equal to that of the general population.

We are extremely pleased that these important provisions contained in S. 2166 have been retained in the new Indian health reauthorization bills now under consideration in the House and Senate. In essence this year's proposed legislation is a nearly identical, yet improved verison of the Indian health bill that received such overwhelming support last year from the Indian community and the 98th Congress.

The new bills are an improvement over S. 2166 because several provisions deemed objectionable by the Administration last year have been eliminated. Both the House and Senate bills have dropped the two provisions that were the basis for the President's veto: the Montana demonstration program and a congressionally appointed commission on the organizational placement of the Indian Health Service. In addition, several IHS reporting requirements have been removed and authorization levels have been lowered, again in deference to the Administration's objections to S. 2166. We endorse these changes and hope that they will lead to a swift congressional approval of the legislation. We are also hopeful that the Administration will demonstrate the strong commitment--expressed by the President in his veto message--to improving the health status of Indian people by supporting the enactment of this critically needed legislation.

We would now like to turn our attention to several specific provisions of the House and Senate versions of the "Indian Health Care Amendments of 1985."

I. Community Health Representatives

NIHB and NCAI strongly support Section 108 of the Senate bill (S.277), which describes the Community Health Representative program and specifies that authority for these health activities derives from the Snyder Act of 1921. For more than a decade the CHR program has operated under Snyder Act authority to deliver a wide range of health-related services to reservation communities. As noted frequently by the IHS medical community, CHR's are an integral component of the Indian health care system and have been especially effective in the areas of health promotion, outreach and health education. In FY 1985, an estimated 1,500 CHR's will deliver approximately 1.96 million health care services in the areas of general health care, dental care, gerontological care, maternal and child care, mental health, and environmental health. The provisions of Section 108 will strengthen and protect this important program in the coming years.

II. Health Services (Title II)

One of the strongest and most important aspects of S. 2166 was its emphasis on improved tribal involvement and consultation on matters related to the planning and delivery of health care services. We are especially pleased with the provisions mandating the update and use of the tribal specific health plans. Consistent with this health planning process, we request that language in Section 201(b) and 201(c) of the reauthorization bills be changed to address the health care deficiencies and health planning activities of tribes and service units, as exemplified in Section 201(b)(2) and Section 201(c)(1)(B)(i) of the Senate bill. This will ensure that the most appropriate local entity has responsibility for the activities described in this section.

III. Health Promotion and Disease Prevention

Among the most serious problems in Indian communities are diseases and illnesses that can be best addressed through health promotion and disease prevention services. Reductions in health problems associated with smoking, alcohol and drug abuse, poor nutrition, high blood pressure, accidents, and environmental hazards will lead to substantial improvements in the overall health status of Indian people.

NIHB and NCAI strongly support Section 204 of the Senate bill which proclaims the importance of health promotion and disease prevention activities; requires IHS to work with tribes to develop a comprehensive community-based approach to health promotion and disease prevention in the tribal specific health plans; and requires IHS to establish a schedule for the provision of health promotion and disease prevention services. We view this section as an important initiative that will provide a new direction to the Indian health program and help control the rising cost of medical care in future years.

IV. Medicare/Medicaid Reimbursements

As noted in our testimony last year, we strongly endorse changes in Title IV that would expand the current authority for the collection of Medicare and Medicaid reimbursements. However, we are concerned about continued efforts to require that revenue collected under this authority be used to offset IHS direct appropriations, and we ask this Committee to strengthen existing language defining the intent of these funds. Specifically, we believe that it must be reiterated that Medicare, Medicaid and other third party collections are supplemental to IHS appropriations and must be used solely for the purpose of enabling IHS facilities (whether operated directly by IHS or by tribal contractors) to meet national health accreditation standards.

We also request that all third party funds (or at least a larger portion than the 50 percent required in Section 402(b)(1) and 403(d)) be returned to the local facilities that made the collections. In addition, NIHB and NCAI support Sections 404 and 405 of the Senate bill, which provide for a demonstration program on direct billing of Medicare, Medicaid, and other third party payers.

V. Health Services for Urban Indians

We fully support Section 502 of the Senate bill, which specifies that authority to provide health services to urban Indians is derived from the Snyder Act of 1921, and we ask that this Commitee continue its support of urban Indian health projects as a separate line item activity within the IHS budget.

VI. Office of Indian Health Service

The proposal to reorganize the Indian Health Service within the Department of Health and Human Services received broad support from tribes, Indian organizations, and other interested parties during last year's reauthorization hearings. Mired at the bottom of the DHHS bureaucracy, IHS continues to be subjected to unnecessary and duplicative reporting and review requirements. Further, administrative authorities necessary for the efficient management of the Indian Health Service (e.g., contracting, facilities planning, personnel) are vested in other agencies within the Department. The results of this bureaucratic overburden are unwarranted and wasteful delays in reporting, contracting, facilitiies construction, decision-making, and virtually every other aspect of IHS operations.

NIHB and NCAI strongly support the establishment of the "Office of Indian Health Service," which would be administered by an Assistant Secretary for Indian Health, as provided in Section 601 of the House bill. We believe this reorganization would consolidate the necessary personnel, functions, and responsibilities of the Indian health program under one authority, which would significantly improve the management and accountability of the Indian Health Service.

We also support the House provision requiring completion of the reorganization within six months after enactment of this section. We believe the comparable Senate section (Section 601(f)), which specifies that the IHS reorganization (to an agency level within the Public Health Service) take effect May 30, 1987 provides for an unnecessary delay in this process, and we therefore oppose this provision.

The remaining sections of the House and Senate bills are basically the same as those contained in last year's Indian health reauthorization bill, and they have our full support. We wish to restate our concern about the urgency of this bill. A number of existing Indian health programs now funded under the Continuing Resolution Act will be jeopardized if a new bill is not reported out by the House and Senate Committees prior to the May 15 deadline for consideration in the FY 1986 budget. Again, we commend this Committee for its prompt action on the reintroduction and consideration of this bill.

This concludes the joint testimony of the National Indian Health Board and the National Congress of American Indians. We would be happy to answer any questions, and we stand ready to assist this Committee in any way possible.

RECOMMENDATIONS ON THE PROPOSED SENATE AND HOUSE BILLS REAUTHORIZING THE INDIAN HEALTH CARE IMPROVEMENT ACT OF 1985

Submitted by
The Inter Tribal Councils of Arizona & Nevada
Uintah & Ouray Tribe
Paiute Tribe of Utah

The Inter Tribal Councils of Arizona and Nevada, the Uintah and Ouray Ute Tribe, and the Paiute Indian Tribe of Utah are very pleased by the expendient and efficient manner in which the Senate Select Committee on Indian Affairs and the House Interior and Insular Affairs Committee have moved to reintroduce bills to reauthorize the Indian Health Care Improvement Act. The Indian Tribes of Arizona, Nevada and Utah consider this proposed legislation vital to improving the health conditions of the American Indian peoples.

The following comments are directed at both the Senate and House versions of the proposed legislation:

I. The Community Health Representative Program (S.B.)

The Tribes strongly support the Community Health Representative Program as a specific authorized program as stated in the Senate Bill under Title I, Sec. 108.

II. Health Services Improvement of Indian Health Status (S.B. - Title II, H.B. - Title II)

As a matter of equity it is proposed that Section 201 (b) (3) of both the House and Senate Bill refer to both the entities "Tribes and Service Units". The sentence would read, "To the extent that all or a portion of the funds appropriated under subsection (h) are required to raise service units and Tribes which are below a Level II deficiency....."

Under "(c) (1) (A) of both the Senate and House Bill we recommend, again that both "Tribe" and "Service Unit" be included to read as follows "the methodology for determining tribal health resources deficiencies; the level of health resources deficiency for each service unit and Tribe...."

The inclusion of "Tribe" as an entity along with Service Unit or comparable entity in the Senate Bill in (c) (1) (B) (i) is supported by the Tribes.

III. Health Promotion and Disease Prevention (S.B. - Title II, Sec. 204)

Diseases associated with stress, nutrition, drug abuse, accidents and environmental conditions are among the primary contributors leading to the need for expensive medical care.

The Tribes strongly support the inclusion of Sec. 204 that notes the importance of health promotion and disease prevention as a method of reducing the rising cost of medical care.

IV. Safe Water and Sanitary Waste Disposal Facilities (S.B. - Title III, Sec. 302, H.B. - Title III, Sec. 302)

It is recommended that (A) under (d) (1) of Sec. 302 read as follows: The secretary, acting through the service is authorized to provide "financial and technical assistance to Indian tribes and communities for the development of tribal operation and maintenance capabilities, and for equipping the appropriate tribal utility responsible for operating and maintaining tribal sanitation facilities." As the sentence now reads in both bills, the emphasis is on the establishment of utility organizations and excludes other mechanisms such as a tribal utility department that may be a more appropriate entity for a number of tribes. Separate utility organizations are not always feasible.

Additionally, the financing of on-going operations and maintenance activities and the financing for renovation of old and worn-out systems continues to be major problems for Indian Tribes. The financial and technical assistance to tribes to develop the capability of providing on-going operation and maintenance of utility systems is just as important as the construction of systems. Safe water and sewage and solid waste disposal systems have had major, dramatic affects on improving the health status of many Indian reservation populations. However, operation and maintenance is needed to continue this progress and to address continued environmental health problems.

V. Medicare provisions (S.B. Title IV Sec. 402, H.B. - Title IV, Sec. 402)

The Tribes, as in previous testimony strongly support the Senate and House amendments to the Medicare and Medicaid provisions. These amendments would allow for greater flexibility and efficient use of the resources. For example, tribal governments that currently provide home health services could become Medicare-certified home health care providers, collect reimbursements for services to Medicare-eligible Indians, and then be able to extend their services. We especially support the eligibility of tribal governments, as well as IHS, to collect Medicare and Medicaid reimbursements.

We recommend that in Sec. 402 (b) (1), 50% be changed to 100% to read as follows: "each service unit of the Indian Health Service receives 100 percent of the amount to which the providers and rural health clinics of the Indian Health Service are entitled......"

VI. Medicaid Provisions (S.B. - Title IV, Sec. 403, H.B. - Title IV, Sec. 403)

It is recommended that under Sec. 403 (d) the sentence that begins "In making payments from such fund" the sentence continues to read as follows "the Secretary shall ensure that each Area Office receive 100% of the medicaid amounts collected in their respective Area, and that each Service Unit of the Indian Health Service receives at least 75% of the amounts to which the facilities of the Indian Health Service, for which such service unit makes collections are entitled...." The bills presently reads that at least 50% of the amounts collected by the service unit be returned to the service unit that made the collection.

There are a number of other concerns with Medicare and Medicaid collections:

- We believe that IHS should be required to account for their distribution of Medicare and Medicaid funds, so that service units that generated those dollars may see where they are going.
- There is wide variability among service units in efficiency of Medicare/Medicaid billings and collections. Some service units in the Phoenix Area collect up to 60% of their billings, others as low as 35%. If the Medicare and Medicaid dollars were returned to the Area and Service units where these funds are generated there would be more incentive to collect payments.

We recommend the following specific changes in third party policies, which would enable both IHS and tribal health facilities including but not limited to those operated under P.L. 93-638 to maximize efficient use of these resources, without jeopardizing the base of federal support for Indian health:

1. The bill should contain a statement of policy which clearly authorizes IHS and tribally operated health programs to receive payments from all third party health financing resources which would include private health insurers in addition to Medicare, Medicaid and others.
2. This policy statement should clearly define third party revenue as supplemental to IHS appropriations as opposed to being used to supplant IHS appropriations.
3. Authority for Indian tribes to utilize funds from other federal agencies in support of the health care delivery system, when the tribal governing body and the agency agree upon the use of the funds. This will address any future "augmentation" questions.
4. Authority be given to Service Units and tribally operated facilities to bill third party resources directly and to be reimburse directly.
5. Authority for tribally operated facilities to develop and generate itemized and accurate statements of service costs, in order to reflect actual costs of services, for reimbursement purposes.
6. Authority for tribally operated facilities to include reasonable depreciation costs for facility and equipment ~~air, renovation, and replacement in the rate structure.

7. Authority for depreciation costs to be placed in a separate fund with accrual and interest generating authority.
8. Authority for expenditures of all third party revenue to reside with the local facility administrator. In the case of an IHS operated facility, concurrence from the tribal governing body should be required prior to expending third party revenue.

However, we do support the intent of the "Demonstration Program for Direct Billing of Medicare, Medicaid and Other Third Party Payors" in the Senate Bill with the following recommended additions.

VII. Demonstration Program for Direct Billing- (S.B. Sec. 405)

We recommend that:

- "including private health insurers" be added immediately following "any other third-party payor." This is to insure that private insurers will know that collections from them are authorized.
- (c) (2) be changed to read "the Secretary shall, prior to October 1, 1986 enter into agreements with qualified entities that wish to participate in the demonstration program......."

Given the drastic reduction in health resources for Indian Health Service it would be inappropriate to limit the selection of the demonstration to only four facilities. This could be extremely detrimental to other qualified facilities that need additional resources to continue their operations.

VIII. Organizational Improvements - Management Information System (S.B. - Title VI, H.B. - Title VI)

Section 601 of the Senate Bill is strongly supported. A services based cost accounting system that permits a service unit to determine its cost based on specific health treatments or services is essential to the establishment of an efficient health care provider system.

We recommend that under 601, (c) and (d) be added that reads as follows:

(c) all automated data processing costs for IHS shall be a separate line item in the Indian Health Service budget.

(d) The appropriate Indian Health Service entity and the affected Tribe and Service Unit should mutually determine the cost accounting system to be used to assure the compatibility of the systems to be utilized.

IX. Service to Ineligible Persons (S.B. - Title VII, Section 713, H.B. - Title VII, Section 713)

We strongly support the provisions of this section, specifically the provision that addresses the collection of fees for services and the credit of these fees to the account of the facility providing the service; and a provision that allows Tribes to revoke services to non-eligible persons. However, with regard to the collection of fees, IHS has no system for determing "actual costs" of IHS services. IHS services units do not use cost-based financial management systems. IHS expenditures are accounted for by object class, and by appropriations line-item. But IHS funds are not accounted for by inpatient or outpatient service categories. Therefore, it would be impossible, under the current management system, for IHS to establish fee scheduled for non-Indian patient payments without conducting cost-finding studies on specific service units.

X. Office of Indian Health Service (H.B. Section 601)

The Tribes support the the establishment of the "Office of Indian Health Service" as proposed in the House Bill, to more effectively and efficiently carry out the responsibilities, authorities, and functions of the federal governments to provide health care services to Indian people and communities.

Mr. TAYLOR. I would like to call a panel of two witnesses next: Dr. Emery Johnson, accompanied by Steven Unger and Father Ted Zuern.

Steve, I see you are sitting in the middle, and I think Dr. Johnson is going to testify on behalf of the association, so I am going to turn the microphone over to you.

STATEMENT OF STEVEN UNGER, EXECUTIVE DIRECTOR, ASSOCIATION ON AMERICAN INDIAN AFFAIRS, ACCOMPANIED BY DR. EMERY JOHNSON, FORMER DIRECTOR OF THE INDIAN HEALTH SERVICE

Mr. UNGER. My name is Steven Unger. I am executive director of the Association on American Indian Affairs. On behalf of the association, I am pleased to have this opportunity to express our support for S. 277.

The association, the largest Indian interest organization in the United States, has 50,000 members and contributors who live throughout the Nation. We thank this committee and the Congress as a whole for its continuing support of this legislation.

The members of our association have supported the Indian Health Care Improvement Act in the past and continue to be strongly behind its basic mission of bringing Indian health care up to a par with the rest of America. To our association, support of the programs in the Indian Health Care Improvement Act is essential, not only to the physical, mental, and social well-being of Indian people in their communities, but also so that the American people as a whole can assure American Indians of the sense of stability, trust, and fairness that is essential in their relations with the majority society.

With me is the former Director of the U.S. Indian Health Service, Dr. Emery A. Johnson, who serves as a consultant to the AAIA on health matters. Dr. Johnson will testify for the association regarding our specific concerns about the bill before the committee.

Dr. JOHNSON. I know it is customary to begin our testimony by expressing our pleasure at appearing before the committee. I must say today that it is really with a sense of sadness that we have to be here at all. This committee and the Congress passed, in my judgment, an excellent bill in the last session, and the veto was, I think, most unfortunate.

I also regret that the bill that we are now considering today, S. 277, is not being presented as the administration's bill. It is a bill that, as I see it, provides very powerful support for the President's own Indian policy, the policy that he expressed on January 24, 1983, particularly since you have eliminated the two specific objections that the President had. I see no reason why this bill should not be the administration's bill, and I am a little bit concerned that the administration witnesses again come before this committee now raising other kinds of issues. I would certainly hope that as we go through the negotiations on this one, we do not end up with some last minute zingers as we had the last time.

I will be very brief in covering the issues. I have a prepared statement that you have available to you, and I will not try to go over all the points.

One of the provisions in the vetoed bill that is not in either the House or the Senate bills this time and was the subject of considerable discussions this morning between Senator Melcher and Dr. Graham, I think, ought to be laid on the table as, in fact, a real problem. I am referring here to that provision of the demonstration project in Montana that would really have the effect of limiting the access of some Montana Indians to certain health services otherwise available to citizens of the State.

That is, in fact, a real problem. There are four different groups that are affected adversely by the nature of that problem. First of all, is the physician who has a patient who, in his judgment, should be sent for hospitalization or for some specialty care. The physician may be reluctant to refer that patient because of concern over this hassling as to who is going to pay the bill or whether the patient may end up then being hassled for the payment of the bill.

Obviously, the patient is adversely affected. The patient finds himself subjected to pressure from private hospitals to pay a bill while two agencies, the Federal Government and the county government, are arguing over who should pay.

The third group is the hospital, the private hospital. They are already under stress because of the cost containment initiatives of the Federal Government, of insurance companies and private industry. Here, again, they find themselves with a real cash-flow problem. They have delivered service in good faith and yet two government agencies are arguing as to who should pay the bill.

Finally, of course, we have the local government officials who, with very limited tax bases, find themselves faced with a potential additional cost to their tax base.

Now, having agreed that this is a real problem, I must say that the proposal suggested by Senator Melcher in the last bill and raised again today is, in fact, the wrong way to approach it, in my judgment. It is a step back. As late as the 1960's, the State of Montana still had what was called the "Ward Indian Statute," a law which in a sense singled out Indian people for denial of certain privileges within that State that were otherwise available to citizens.

I think that any kind of provision that we take that suggests that we are again raising that issue is wrong. We thought we had put that behind us 20 years ago with the passage of the Civil Rights Act and the negotiations that went on with the State of Montana. I was a personal participant in negotiations with the Governor of Montana, with the congressional delegation at that time, and I thought we had put that behind us.

Certainly, we have to deal with this problem, but there are actions that could be taken, administratively and through negotiations, in my judgment, that could do much to relieve this problem and to get all the facts on the table so we can understand precisely what has been happening. This rather general approach of the Montana provisions, which seems to me to be going back to saying that somehow or other Indians are not to be treated the same as other citizens of the State, is the wrong way to go.

The precedent that Senator Melcher raises in the Bureau of Indian Affairs is one approach, of course, the "in lieu" of tax approach. Impact aid is a well understood mechanism for military and other Federal impact aid, if that is the problem. But to single out Indian people for some kind of special treatment by the government of the State of Montana is, I think, most inappropriate.

Mr. TAYLOR. Dr. Johnson, on behalf of Senator Melcher, I would like to interject a comment at this point. I am sure that it is the last thing in his mind that his amendment should be read as in some way creating some bar or impediment to Indians receiving health services. In fact, as that amendment reads, it certainly does not establish such a bar or impediment statutorally. As I recall, what it says is that in providing health care to indigent Indians, the Indian Health Service may not consider the fact that such person may be entitled also to free medical services through a State or county government.

In his veto message, President Reagan indicated that this created a bar to Indian access to health services. Certainly, on the face of that amendment, it does not say that.

Dr. JOHNSON. I think you are absolutely correct in the statement in the bill. The problem is that if it is not intended to do that, then there is in fact no purpose for having that provision in the bill. The purpose of that provision clearly is to enable the local governments in the State of Montana to avoid paying for bills for certain Indian people.

Mr. TAYLOR. Or at least authorize the Federal Government to share some of the load.

I might just comment, this obviously is going to be a subject of great contention within this committee, probably on the floor of the Senate, probably in our dealings with the House, and definitely in our dealings with the administration. So, I do appreciate your putting your views on the record here, but I just felt compelled to make this observation on the Senator's behalf.

Dr. JOHNSON. I appreciate the Senator's position, and I do support, as I think you made note, his desire to resolve this problem. It is not a problem that is going to go away by ignoring it. That is not my position, to ignore that problem. I am just saying I think we must look for other alternatives than one that appears to be taking a step backward.

Mr. TAYLOR. Do you feel there is a problem that is present.

Dr. JONNSON. Yes.

To proceed, I think that we have heard good testimony this morning about the importance of the community health representatives. I think it is unfortunate that the administration repeatedly suggested that somehow or other they are peripheral or fringe or sort of an unnecessary luxury. Quite the contrary. The community health representatives, as health services are delivered in the Indian Health Service and in the Indian communities, are in fact the prime access point to that delivery system for the members of that community. They have been a most effective method of providing that kind of access.

I am a bit concerned—and I will depart a bit from my prepared statement here—that their opposition here again and their budget proposals this year suggest to me that this administration is suggesting that we should go back to the medical care delivery system that we found in place at the time of the transfer. That was basically a program where you had nothing but clinical medicine, essentially, where the doctors and nurses sat in that hospital and waited for somehow or other the sick Indian to make his way to the doors. If he could make it, he might get some help.

We in the Indian Health Service spent 25 years trying to turn that around so that you get the health program accessible to the patient in his home and in his community. That is what preventive medicine is all about. Again, to see this pious discussion of health promotion and the national goals for healthy people, when you have an administration that has singled out preventive services for their major cuts in the President's budget request, strikes me as a point where we ought to say, let us not have the rhetoric. Let us look at what your actions are.

The President's budget is proposing a 40-percent reduction in the preventive services. How do you achieve national goals for healthy people if you are cutting out the very programs that are the basis for that kind of health promotion?

Back to our bill, if you look at both title II and title III, you have a couple of very powerful initiatives there to assist in carrying out the President's Indian policy. We have the provision for full disclosure so that the Congress can understand the resource needs of each tribe. We have a reinstitution of the tribal health planning process which was initiated by the original bill and has since fallen on hard times. We have the ability to permit tribes to get equal treatment in the allocation of resources, both for services and for the construction of facilities, whether they are operated under 638 or operated directly by the Indian Health Service. Those are just a couple of very explicit examples of how this bill goes right down the line in support of the concept of self-determination that the President has stated as being his primary Indian policy.

We note the improvements that have been made in title IV. It is obvious that the dramatic improvements that have been made in the quality of health services are because of the funds that are available under title IV.

I think we must note, however, the continued unrealistic projections that are presented in budget documents to the Congress from the administration. These projections can have no basis in fact and have been proven to be dramatically wrong each time they have been presented.

It would appear to me that the only basis or reason for making those projections is to somehow or other support the diversion of $10 million from the stated purpose of those funds in the act to routine cost increases. If you show twice as much in your projected reimbursements than you are actually going to get, $54 million versus what you might get, say, $28 million, obviously $10 million out of $54 million does not look like very much, but $10 million out of $28 million is a very substantial reduction in that fund which, in my judgment, should not be diverted for those purposes.

Well, we finally get to the Urban Programs, title V. They are, in fact, the "safety net" for urban Indian people.

We have asked, and you have asked, and the other committees have asked, repeatedly for the administration to provide the study that was done to show that these other resources are in fact available. I do not believe any of us have ever seen the study, yet they continue to say these services are available. Studies that have been done by Urban Programs and testimony before this committee, including testimony from some of the very institutions that the administration claims will be available to provide that service, tells us just the opposite.

I think the comment that was made by the chairman earlier this morning is quite apropos. Until the administration can present some real facts to demonstrate that there are these other resources, I would hope that the Congress would not consider, in any way, the elimination of the Urban Programs.

Then we get to the issue of the elevation of the Indian Health Service to the level of an agency within the Public Health Service. We have discussed in previous testimony example after example of the problems that are created by the remoteness of the Indian Health Service from the decisionmaking levels of the Department. Administration officials have repeatedly acknowledged these problems; they have not attempted to refute them at all. Yet, they persist to assume that they will go away.

To show that these problems are still with us, I might just give you another example to add to the long list of examples we have given before. In the fall of 1983, the House Appropriations Subcommittee directed the administration to provide them a study on indirect costs as they relate to the operation of contracts under Public Law 93-638. That report was also to include recommendations for resolving the problem.

The Indian Health Service, rather promptly, within a few weeks, developed that report, and it started the clearance process through the Department. We are now a year and a half from that request from the Congress and, to the best of my knowledge, that report on indirect costs has never reached the Congress.

Now, if we cannot get a handle on this indirect cost issue, we are going to bring the 638 process to a halt. We were very close, just 2 to 3 weeks ago, of having a major Indian health program retroceded by a tribal government because of the inability to get a handle on indirect costs. That disaster was narrowly averted, but it is only a matter of time. It certainly is going to put a very serious restriction on other tribes who may choose to want to contract.

How in the world can we expect Congress to legislate effectively if you cannot get access to the expertise of the agencies that you are trying to oversee? There is no excuse that I know of for a year and a half to get that kind of a document up to the committee, and there are example after example of this type of performance.

Questions were raised this morning about what specifically does HRSA do, and we got very little answer, I believe. One thing that was raised is that they handle the contracting. As we all know, in every hearing that has been held throughout the country, the problem of contracting, particularly as it relates to 638, has been a major problem in the eyes of the tribes. Yet, that is one of the major functions that HRSA provided for us.

We can really identify very few things, if any, that HRSA does that are not already provided or done by the Indian Health Service or by the Assistant Secretary for Health, or by both. At a time of this great concern for the Federal deficit, when the administration is proposing dramatic reductions in health services for Indian people, it does not seem appropriate for them to so tenaciously cling to the need for maintaining these multiple layers of the bureaucracy. It is the administration's overhead that should be reduced, not health services for Indian people, and the easiest, most effective way to cut that overhead is that proposed in S. 277, the elimination of one layer of that Federal bureaucracy above the Indian Health Service.

After listening through this morning, I really find it necessary to comment on some of the expressed concerns raised by the administration on that issue. We have talked about contracting. The experience that I see, the examples that I am picking up from my contacts with people in the field, is that contracting is probably getting worse, not better. There are additional efforts to make more complicated the whole contracting process, to include in the procurement process things which were never there before.

The one thing that is lost, it seems to me, when you are dealing in the traditional contracting or procurement line is that Public Law 93-638 is not a contracting law. We are not buying loaves of bread or Trident submarines from Indian tribal governments. We are transferring a Federal function to a tribal government, and that is not procurement. Yet, by continuing to wrap this up in all of the trappings of the procurement process, we are continuing to frustrate both the tribes and the Indian Health Service.

Now, to go back to some of their expressed concerns, they have claimed, the administration has claimed, that the elevation of IHS will not improve the efficiency or effectiveness of the Indian health program but might even make things worse.

A wise man has said that those who not understand history are doomed to repeat it. The record will show that the Department of Health, Education, and Welfare, in testimony before the Congress, in 1953 and in 1954, argued that, "the transfer would not solve and might accentuate Indian health problems." Further, the Bureau of the Budget remained unconvinced to the end that the transfer was justified in terms of economics, improvements in efficiency, or more effective administration.

Now, of course, we find the officials of that same Department come before the Congress to boast, and I think with good reason, about the dramatic improvements made in the health of Indian people since the transfer and suggesting perhaps that the transfer had something to do with it. Fortunately for Indian people, the Congress, in its own wisdom, ignored the predictions of disaster from the adminstration and proceeded to direct the transfer. The results speak for themselves.

If the Congress follows the course of its own wisdom again today, I predict that when we come here 30 years from now to consider another change in the Indian Health Service, the administration will come before us again and claim dire consequences of making any change while, at the same time, boasting for all the good things that have happened because the Indian Health Service was now a constituent agency within the Public Health Service. Such is the nature of the bureaucracy.

The second issue is the claim of the administration that changing the organization of the Indian Health Service will do nothing to improve the functioning of the Indian Health Program. That is interesting, because they have never refuted the problems that have been raised over and over again by Indian tribal governments, by former and present Federal officials, and by knowledgeable health people about the obstacles and the frustrations that are created by this multilayered bureaucracy.

There is a sense in which the administration's position seems to be that there is no hope for any improvement, so you might just as well let the status quo remain. If I were an official of this administration, I do not believe that I would want to be defending a position that claims that management cannot be improved.

The third charge that has been made is that the elevation of IHS would be expensive and disruptive. On the contrary, it is the present layering of the bureaucracy within the Department which is expensive and disruptive. What is proposed in this bill is not the addition of another bureaucratic layer, but the elimination of an entire layer of the bureaucracy above the Indian Health Service, a layer which essentially duplicates the work of the Indian Health Service and/or the Assistant Secretary for Health of the Department of Health and Human Services. How the elimination of a layer of the bureaucracy could cost us money is really beyond me. What would happen should be a substantial savings in personnel and funds, resources which would be more appropriately provided to deliver health for Indian people.

President Reagan, in his Indian policy statement, noted that:

> Excessive regulation and self-perpetuating bureaucracy have stifled local decision-making, thwarted Indian control of Indian resources, and promoted dependency rather than self-sufficiency.

It is the self-perpetuating bureaucracy that is at issue here today, and S. 277 moves directly to support the President's policy.

The Indian people should no longer have to bear the burden of this self-perpetuating bureaucracy, nor should the American taxpayer have to continue to pay for it.

Enactment of this bill will reaffirm the commitment of the U.S. Government to the goals of Indian health and will assure continued progress by Indian people in their health programs. I would urge the committee to move expeditiously on this bill, and I would be glad to answer any questions that you may have.

Thank you.

[The prepared statement follows:]

PREPARED STATEMENT OF THE ASSOCIATION ON AMERICAN INDIAN AFFAIRS, PRESENTED BY EMERY A. JOHNSON, MD, MPH, ASSISTANT SURGEON GENERAL, RETIRED, U.S. PUBLIC HEALTH SERVICE

It is customary to begin testimony by expressing pleasure in appearing before the Committee. In the present case, however, I must express a sense of sadness that it is necessary to again be testifying in support of the reauthorization of the Indian Health Care Improvement Act; the bill passed by the Congress in the last session was, in most respects, an excellent bill and its veto was, in my judgement, most unfortunate. I also regret that this bill, S.277, has not been introduced as the Administration's bill as it provides powerful support for President Reagan's Indian Policy as set forth in his statement of January 24, 1983 and has eliminated his two specific objections to the previous legislation. Nevertheless, I am pleased that the bill has been reintroduced and am pleased to provide my comments and recommendations to the Committee.

Reauthorization of the Indian Health Care Improvement Act is essential to maintain the commitment of the Federal government to the Indian and Alaska Native people and to continue the progress toward meeting the "national goal of providing the highest possible health status to Indians and to provide Indian health services with all resources necessary to effect that policy". That Act, along with its companion legislation, the Indian Self-determination and Education Assistance Act, set in motion a decade of sustained progress by the Indian tribal governments, in partnership with the Federal government, in developing effective health services and in improving the status of Indian health. The Act was a comprehensive and coordinated set of actions designed to assure adequate health manpower for Indian health facilities through recruitment and scholarships (Title I), to provide and improve a defined set of health services, both preventive and curative (Title II), to improve access to high quality health services through the construction of Indian hospitals and health centers and to assure the provision of safe water supplies and sanitary waste disposal through the construction of sanitation facilities for Indian homes and communities (Title III), to facilitate access to health services and to improve the quality of services in IHS hospitals and clinics by authorizing the IHS to receive reimbursement from Medicare and Medicaid (Title IV) and to assist urban Indians to obtain necessary health services (Title V). As a result of this legislation, Indian tribal governments have a clear vision of a health services system which will meet the highest national standards and which will be planned and managed, to the extent they desire, by the tribes themselves.

The results to date have been impressive. Although the appropriations envisioned by the Act were not attained, real advances were made in response to each of the titles. Several hundred Indian people have been recruited and trained in health professions and health occupations; substantial progress has been made in improving access to health services and in the quality of services; seven new hospitals and nine health centers have been completed and a dozen more are in various stages of development; sanitation facilities have been provided to over 30,000 Indian homes; careful utilization of the Medicare/Medicaid reimbursements have resulted in the increase in the number of hospitals accredited by the Joint Commission on Accreditation of Hospitals from 24 to 40 along with initial accreditation of 14 health centers—a clear indication of improved quality. Urban Indians have been able to receive greatly improved health services with more than 500,000 services being provided by the 37 urban Indian health projects. By effective management, these urban projects have also been able to develop linkages to other community health resources and have generated additional funding almost equal to the IHS funding, further expanding the level of essential services available now to the urban Indian.

The ultimate objective, of course, is found in the steady improvement in Indian health status. Infant mortality continues to decline; life expectancy continues to increase. The excessive burden of infectious diseases is giving way to the chronic disease patterns commonly found in the general US population. In spite of these demonstrable improvements, however, there remain severe deficiencies in health service resources and in health status. The initiative so effectively begun must not be allowed to falter; reauthorization of the Indian Health Care Improvement Act is essential if the investment in improved Indian health is to be preserved.

I would now like to address some of the specific provisions of S.277. Since most of these provisions are similar to those in the bill passed by the last Congress, I will not discuss most of them in any detail again.

One of the provisions of the vetoed bill, although deleted from S.277, did address a real problem but with, in my judgement, the wrong solution. I refer to the provision for a demonstration project in Montana that would have had the effect of limiting access of Montana Indians to certain health services otherwise available to Montana citizens. There are four groups which do, in fact, have problems with the situation in Montana where the Federal government and the county governments are in dispute over who should be responsible for the cost of health services provided to certain Montana Indians: the physician who is concerned about his patient who needs to be referred for hospitalization but may be reluctant to refer because of the potential financial liability facing his patient; the patient who finds himself subjected to pressure from the hospital to pay the bill while the two government agencies argue as to who should pay; the hospital, already under stress from the cost-containment efforts of government, insurance companies and private industry, who is forced to wait for payment while the dispute between the Federal and local governments continues; and the local government officials who, with a limited tax base, are faced with potential expenditures for health services for certain Indians. However real the problem, however, the provision in S.2166 was a step backwards. In the 1960's, the State of Montana still had a "ward Indian" statute which denied certain citizenship rights to Montana Indians. Many of us have worked for twenty years to assure that Indian citizens not be denied their citizenship rights; any provision that may erode that progress should not be considered. Certainly there are actions that can be taken, within current authorities, to identify all of those factors in the problem that can be corrected now and to design, if necessary, a solution without the inherent problems of the provision in S.2166.

TITLE I

As the cornerstone of any attempt to expand the ability of Indian tribes to develop their reservation economies, the health of the people requires trained health professionals. The Indian Health Scholarships authorized by this title are the essential component; failure to reauthorize this title would be a tragedy for those Indian students who aspire to serve their people as doctors, dentists, nurses and other health workers as well as for the members of their communities who must rely on them for the staffing of the Indian communities' health facilities. Identifying the Community Health Representatives as an essential component of the basic Indian health system under the authority of the Snyder Act will strengthen that most important service; CHRs are not a peripheral service but are, in fact, the fundamental access point for the Indian patient into his health services delivery system.

TITLE II

Continuing the systematic improvement in access and in quality of health services is the essence of this title. By requiring the reinstitution of the Tribal health planning initiative of the initial Act and by providing for "full disclosure" to the Congress of the resource status of each tribe, this section provides a powerful tool to support the tribal self-determination process—one of the major points in the President's Indian policy.

TITLE III

Again we must note the substantial unmet need; more that 160 Indian health facilities which must still be considered for new construction, modernization or replacement and the more than 38,000 Indian homes which still lack safe water supplies and/or sanitary waste disposal systems. The provision for "full disclosure" of the status of each tribe and the requirement that facilities operated by the tribes under PL 93-638 be considered on an equal basis with IHS-operated facilities again support the President's Indian policy.

TITLE IV

As noted earlier, the availability of these funds to apply to corrective actions to attain and maintain accreditation of Indian health facilities has had a dramatic effect on improving the quality of health facilities. We must note, however, the continued unrealistic projections of the amount of reimbursements by the Administration and their efforts to divert these funds away from the stated purpose into routine operating costs. Acceptance of that approach can only result in delay in obtaining the necessary standards of health care, if not resulting in deterioration of the improvements made to date; these efforts by the Administration should be rejected.

TITLE V

The urban Indian health services are, in fact, the "safety net" for these people. While the Administration has repeatedly attempted to eliminate this program by claiming that adequate services are otherwise available to them, requests by the Congress for documentation of these services have gone unanswered. To the contrary, studies by the urban projects have demonstrated just the opposite. Further, many of the very programs that the Administration apparently believes could provide health services to the urban Indian community have gone on record as stating their inability to do so. As recognized in the bill, urban Indian health services are authorized under the Snyder Act and were being supported under that authority before the enactment of the original Indian Health Care Improvement Act.

TITLE VI

This title, providing for the elevation of the Indian Health Service to the level of an agency within the Public Health Service is, in my opinion, one of the most critical improvements in the bill. In previous testimony before this Committee, I have described in detail examples of the problems created by the location of IHS at a level remote from access to the decision-making authorities within the Department of Health and Human Services. Administration officials have acknowledged these problems; that they are not being resolved is evident with yet another recent example. In the fall of 1983, the House Appropriations Committee directed the Administration to provide a full report on the problems surrounding indirect costs in tribal contracts under PL93-638 along with recommendations for correction of these problems. The IHS promptly (within a few weeks) developed the report but the multi-layered clearance process within DHHS has been unable, after a year and a half, to get the report to Congress. The issue of indirect costs is critical; if an adequate solution is not found, the self-determination process can be brought to a halt. Within the past few weeks, a tribe operating their total health program came very close to having to retrocede their program because of the problem with indirect costs. How can the Congress be expected to legislate effectively when they cannot obtain the technical expertise of the IHS?

When one studies the functions of the various levels of DHHS, it becomes apparent that there is a tremendous amount of overlap and duplication of functions. For example, one can repeatedly ask what specific functions does the Health Resources and Services Administration perform that are not also performed either by IHS or the Office of the Assistant Secretary for Health or by both; there have really been no answers. At a time of great concern for the Federal deficit, when the Administration proposes to drastically curtail health services for Indian people, particularly to reduce preventive services, it does not seem reasonable for them to cling tenaciously to the position that all of the bureaucratic layers are necessary. It is the Administration's overhead that should be reduced—not health services for Indian people. The easiest, most effective way to cut that overhead is that proposed in S.277—the elimination of one layer of the Federal bureaucracy above the IHS.

From my experience as Director of IHS, I can say that there are few, if any, functions at the HRSA level that could not have been carried out with equal or, in my opinion, greater efficiency at the IHS level. What was needed was the authority to carry out those functions and the authority to identify and employ the few skilled people necessary.

In previous testimony, I described in some detail the nature of the problems created by and/or accentuated by the present organizational location of the IHS and identified some of the advantages to be gained by elevating IHS to the agency level within the Public Health Service. Normally, I would prefer to leave it on that positive note. However, having noted that, almost alone of all informed witnesses on this subject, the Administration continues to oppose any change in the status quo, I feel it necessary to comment on their expressed concerns.

First, the Administration has claimed that elevation of IHS will not improve the efficiency or effectiveness of the Indian health program but might even make things worse. A wise man once said that that those who do not understand history are doomed to repeat it. This is a classic example; the record will show that the Department of Health, Education and Welfare opposed the transfer of the Indian health program from the Bureau of Indian Affairs in hearings in both 1953 and 1954, arguing that "the transfer would not solve and might accentuate Indian health problems. The Bureau of the Budget remained unconvinced to the end that the transfer was justified in terms of 'economics, improvements in efficiency or more effective administration' ". Now, of course, we hear the officials of that Department boast, with good reason, of the tremendous improvements that have been made in Indian health since the transfer and, apparently, claiming that the transfer was the reason for much of the improvement. Fortunately for Indian people, the Congress, in its wisdom, ignored the dire predictions of the Administration in 1954 and proceeded to order the transfer. If the Congress follows the course of its own wisdom again today, I predict that when another change is suggested 30 years from now the Administration will be back opposing that new change while at the same time boasting of the success achieved by having IHS as a full agency within PHS—such is the nature of the bureaucracy!

The second issue is the claim by the Administration that changing the organizational location of IHS will do nothing to improve the functioning of the Indian health program, although they do not refute the problems that have been presented to this Committee in hearings over the past year. There is a sense in which the Administration's position seems to be that there is "no hope" of improving the Indian health program so the status quo might as well be maintained. If I were an official of this Administration, I don't believe I would want to be defending a position that claims that management cannot be improved.

A third charge has been made that the elevation of IHS would be "expensive" and "disrupting". On the contrary, it is the present layering of the bureaucracy within the Department of Health and Human Services that is expensive and disrupting. In hearings across the country, this Committee has heard from Indian leaders, from present and former Federal officials and other knowledgeable health professionals of the frustrations and other obstacles placed in the way of effective management of the Indian health program by the present administrative layering of DHHS. What is proposed in this bill is NOT the addition of another bureaucracy but, specifically for the Indian Health Service, the ELIMINATION of an entire layer—a layer which essentially duplicates the work of IHS and/or the Office of the Assistant Secretary for Health. How the ELIMINATION of a layer of the bureaucracy could possibly cost money is beyond me; the net result should be a substantial savings of personnel and funds—resources that could more productively be employed to deliver essential health services to Indian people.

President Reagan, in his Indian policy statement, noted that "excessive regulation and self-perpetuating bureaucracy have stifled local decision-making, thwarted Indian control of Indian resources and promoted dependency rather than self-sufficiency". It is that "self-perpetuating bureaucracy" that is at issue here. S.277 moves directly to support the President's policy.

Indian people should no longer have to bear the burden of this "self-perpetuating bureaucracy"—nor should the American taxpayer have to continue to pay for it!

Enactment of S. 277 will reaffirm the commitment of the United States government, as expressed in the original Act, of "providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy" and will assure continued progress by the Indian people and their health programs. I will be happy to answer any questions you may have.

Mr. TAYLOR. Dr. Johnson, I think you have given very thorough testimony. I do not think we have any questions at this time, but we certainly appreciate your statement.

Father Zuern, we have had another shift in plans, and if you want to present your testimony, we would like to receive it.

STATEMENT OF TED ZUERN, S.J., ASSOCIATE DIRECTOR, AMERICAN INDIAN ISSUES, NATIONAL OFFICE OF JESUITS SOCIAL MINISTRIES

Father **Zuern**. I am Ted Zuern. I am a Catholic priest. I represent the National Office of Jesuit Social Ministries, the Bureau of Catholic Indian Missions, as well as the Tekakwitha Conference which is the largest American Indian organization within the Catholic Church in the United States.

I have been a Jesuit for 35 years or actually more. I have been in Indian ministry for 25 of those years. I have served for 10 years at least part-time as chaplain in Indian Health Service hospitals on reservations and also at the Sioux Sanitarium in Rapid City.

My testimony this afternoon is more in the nature of a view from the patient's point of view. What I would stress is the high need for a sensitive crosscultural relationship between the patient and the professional staff. Sometimes we find very good examples, and, yet, so frequently, there is an utter insensitivity as though the technology that we have today or the science of medicine by itself is going to bring about the change. I know in my own experience, my own limited use of the Lakota language with patients, at times, has impressed me with the response that it brings.

So I am especially here in support of title I which provides for the training of qualified Indian students in the health care professions. I think there is nothing that will serve the Indian patient quite as well as someone who is sensitive to the cultural tradition which has formed that individual. I realize that we have hundreds of Indian cultures in this country, yet regardless of what group, nation, tribe, pueblo from which the individual Indian health professional may come, there is a higher sensitivity I think than when an average person coming to tend an Indian patient, because as Americans, I think we have an awful lot to learn about the cultural sensitivity of other people. That is true at home and in our dealings with the Third World. Here it is right in our own country, and it is highly important.

I would stress here sections 501 and 502 in regard to Urban Indian Health Programs. I have served in urban areas, both in Minneapolis and Rapid City, and I have seen the problems that come when people are afraid, a cultural fear and insecurity. I have actually brought patients in by back doors into hospitals because their health was so bad and they wouldn't be admitted in the front door. Not enough appreciation of the needs of that Indian patient as a member of a particular cultural group exists.

What has been said already in regard to the urban Indian health boards is very true. There are obstacles there that unless one appreciates cultural sensitivity, one will never understand. But they are realities, and for those of us who have been involved, it is essential that the opportunity be there for the patient to be treated with the cultural realization of his or her background.

Title I, then, would provide staff. Sections 501 and 502 certainly would continue a very good program that is operating in cities and that I think should be expanded.

I think it is no accident that we have, for example, the highest Indian population in California. I remember back in 1953 and those following years when the Bureau of Indian Affairs began relocating people from their reservation to California. There is a responsibility that has gone with that transfer. I will grant you that some Indians have gone out on their own, but the initial impetus to relocate people came as a Federal program, not always wisely planned, but the people have been relocated.

There is much more that has to be heard by this committee. I do not want to go on, but I think if the Senate realizes the importance of crosscultural sensitivity, the provisions that are made in S. 277 give us something that we can be proud. That bill should be passed into law. So, I simply want to state my support for this bill and encourage its passage.

Thank you.

[The prepared statement follows:]

PREPARED TESTIMONY OF TED ZUERN, S.J., ASSOCIATE DIRECTOR, AMERICAN INDIAN ISSUES, NATIONAL OFFICE OF JESUITS SOCIAL MINISTRIES

My name is Ted Zuern. I am a Catholic Priest and a member of the Society of Jesus with more than twenty five years experience in pastoral, social and educational ministry in American Indian communities in Kansas, South Dakota and Minnesota. I have ministered on reservations and in urban areas. More than ten years of my ministry has included chaplaincy service in Indian Health Service hospitals in South Dakota on the Rosebud and Pine Ridge Reservations and in Rapid City at the Sioux Sanatorium when it was used exclusively for the treatment of tuberculosis patients.

Today I speak for: The Bureau of Catholic Indian Missions which is the oldest agency in the Roman Catholic Church in the United States; The Tekakwitha Conference which is the largest American Indian organization within the American Catholic Church; The National Office of Jesuit Social Ministries in which I am the Associate Director caring for American Indian Issues.

From my past experiences in ministering to American Indian patients in hospitals of the Indian Health Service, I have observed that frequently the most essential element of health care is completely overlooked by health care staff members who are not of American Indian descent. That essential element is treatment of the patient with a sensitivity for his or her cultural traditions—the expectations, the assumptions that the Indian patient has regarding how health care is to be administered. The values and patterns of behavior which have formed Indians in their cultural development are of primary significance in the treatment of an ill or injured Indian person. The approach that is made to the patient must have the quality of his or her culture in it.

The use of products developed by experimentation in scientific fields and the employment of modern medical technology are important, of course, but the health care professional must always realize that for most patients in Indian Health Service hospitals use of these products and techniques are not going to produce the sense of confidence that can be expected from the average patient in the average American hospital where there is a confidence formed by the values of America's modern technological culture. American Indians are aware of scientific developments, but they are not looking for a health care professional coming to them from the sterile world of medical science. They will accept the techniques of modern science, but above all they seek treatment in keeping with the highly personal respect of their traditional culture. They are not simply ill or injured persons. They are ill or injured Navajo or Mohawk or Sioux, or whatever their tribal culture may be, persons. They need to be approached as such if optimum healing is to be expected.

Some health care professionals serve with cross-cultural sensitivity. Others serve with good intentions but without appreciation of the significance that tribal traditions have formed in their patients. They place their highest trust in the health care technologies that are available to them rather than on the cultural expectations of their patients. Thus, such health care professionals fail to detect the cause of their patient's poor response to the technologies used.

The patient's assumptions, attitudes and expectations, which have been deeply established by the cultural tradition in which he or she has been formed, establish psychological influences that have effects on the expected healing process. Only when the patient's culture is grasped, at least to some degree, is there understanding of how modern health care technologies will operate within that culture for that patient. Only then, when the patient recognizes health care that is touched by the traditions of his or her people, can the best response be expected from the use of modern health care technology. The living, psychic qualities of human life demand that an approach to healing be made in the tradition expected by the patient. Today's medical technology is inadequate by itself when used for a patient whose cultural roots are not in today's technological society.

So frequently this cross-cultural psychology is overlooked. Modern medicine is expected to work automatically. The cultural identity of patients is of such high significance in the healing process that it must be considered by those responsible for providing health care to American Indian patients. When this fact of healing is appreciated, the importance of Title I in S. 277 becomes clear. A trained health care professional who bears a cultural sympathy toward the patient is better prepared than any other deliverer of health care in caring for that patient. An Indian doctor, nurse, technician or aide who uses modern health care technology has a great advantage in providing healing for an Indian patient than does one who is not Indian and does not appreciate the patient's culture.

Title I is a very important part of S. 277. It begins to meet a need that all too frequently has been overlooked in the past. In this nation which is composed of populations from all portions of the world, distinct in their cultural formation and world-outlook, no single population has a clearer right to cultural respect than the American Indian peoples who have lived in what is the United States of America from the start and who have never left their homeland in order to seek a new identity in a foreign land beyond the sea.

Title I will benefit not only the qualified Indian students who are enabled to become professional health care staff but also the Indian patients who will receive from them not only the benefits of their professional training but also the cultural sensitivity with which they approach Indian patients. Title I is essential for the improvement of Indian health care in this country.

Because the sense of community remains stronger among the members of American Indian tribes than it does in the general American population, the presence of hospital and clinic staff members who are Indian meets a community need. I suspect that Indian family and community members feel a greater need to support their sick by being present in a quiet way, close to the patient's bedside than is true in the illness of the average American. Staff members who are not Indian frequently become impatient with the presence of family members in such large numbers on the hospital floors when a family member is sick or injured. Only staff members who recognize the cultural obligation that exists in such a circumstance to support the sick member of the extended family can serve with ease under these conditions. The whole Indian community can be aided by the presence of Indian health care professionals in Indian hospitals. Title I provides for the needs not only of the patient and his or her family but also for those of the community.

I stress the need for cultural sensitivity because I believe that it is far more important than the average person realizes. I make this conclusion not only from my training in Cultural Anthropology but from more than twenty five years of ministry among American Indians. Most Americans who are not Indian readily agree that the taking of the Indians' land remains an embarassment that this nation can never escape, but I suspect that a greater injustice was done to American Indian peoples in all the efforts made to remake them and to leave them ashamed of being who they are. Individual Indians have been driven to frustration as they have sought to be true descendents of their ancestors and yet forced to act, at least in public, as though they were being absorbed into the mainstream of United States life where cultural assumptions, attitudes and expectations are so different from, and sometimes contradictory to, their own.

Humanly speaking nothing is worse than being forced to deny one's own identity or to feel that one is inferior to other cultural or racial groups. I recall clearly the day, some twenty years ago, when the father of some of the Indian students I taught confided in me that only when he was drunk did he "feel that he is as good as a white man."

That and other similar experiences have forced me to grasp something of the significance of cultural formation. We do not know how limited we are when we deeply believe that among the varied cultures forming peoples on the face of this earth, that our culture is the best and should be imposed on all other peoples. I have known professioanl health care staff of the Indian Health Service who have such an idea of their cultural perfection and so do not limit their attention to healing Indian patients but seek to change their cultural identity for what they think is "the better." The health care professional in such instances may have good intentions, but the psychological results are disasterous.

Past failures in cross-cultural sensitivity must not become an excuse for their continuation. (I might interject that failure to recognize and respect American Indian cultures is paralleled today by failures to recognize and respect the cultures of other nations, especially those in the third world.)

Title I is a very important part of S. 277.

Sections 501 and 502 of Title V of S. 277 are also very important for the same cross-cultural reasons stressed above. These sections provide for assistance to urban Indian health care projects.

American Indians have not lost their cultural identity because they have been relocated in urban areas. Moreover, the federal government's Indian Relocation Program that began in the 1950's have resulted in almost half of the American Indians residing in urban areas today. For example, it is no accident that the state of California has the largest American Indian population of all the fifty states. Indians were relocated in massive numbers in California from the reservations of the other states. I suspect that whoever organized the relocation program believed that in a short time American Indians would merge into the mass of American urban dwellers. That did not happen. Such relocations of peoples seems to make them more than ever aware that they have a cultural identity and that in some fashion they must hold on to that identity or become part of a community they just do not understand. Each seeks always to hold on to his or her cultural identity because that can be understood, because that is the tradition that has meaning.

Urban health clinics are often expected to provide care for the needs of Indian patients. However, sensitive respect for the cultural needs of the Indian patient are regularly overlooked. The same situation will prevail as in the case of the insensitive health care professional who is not Indian working in an Indian hospital on a reservation.

Because of the cultural insensitivity shown to Indians in so many instances in urban medical clinics and hospitals, Indians in need of health care will not approach those clinics unless there is a dire emergency. The consequence of this behavior is that the standards of health for Indians in urban areas, as studies continue to indicate, are lower than those for Indians on the Indian reservations of this nation.

Provisions for urban Indian health projects are a moral obligation of the federal government. Through the commerce clause of the Constitution of the United States relationships of the tribal governments are restricted to the federal government alone, and not to the governments of the states. It was the federal government that relocated so many Indians in the urban areas of the United States through the Bureau of Indian Affairs of the Department of the Interior. American Indians are in America's large cities because the federal government relocated them there. As the American Indian Policy Review Commission stated in its Final Report, the responsibility of the federal government follows the tribal member through his or her tribe to the urban area where he or she has been relocated and now lives.

The original obligation of the federal government to members of American Indian tribes arises from the federal government's taking of the vast stretches of Indian homelands. Usually under military force tribes signed treaties with the federal government and transferred land titles to the United States. Now more than 95% of the original Indian land is owned by the United States or private parties. Even the lands that tribes still own are held in trust for them by the federal government. Can there be any question of the severe restrictions that such great land losses have placed on tribes? Although, according to the requirements of the treaties signed by the tribes and the United States, some health care provisions have been made for Indian tribal members, it was almost always done without sensitivity toward tribal traditions and life styles. Probably the commissioners of the United States who signed the treaties in the course of the last century suspected that by this time all would be adjusted and the distinct qualities of Indian cultures would be lost. As a matter of fact in the U.S. Census of 1880 approximately only 250,000 Indians remained alive of a population of some millions before the European advent to these shores. But the Indians remain. Today there are more than one and a half million Indian persons in the United States. The promises that were made with the land transfers have not been fulfilled because the course of cultural histories of American Indian tribes has been different from what was expected. The Indians must be provided the opportunity to achieve full personal and community development within the polycultural population of the United States. Legislative bill S. 277 is today's answer to past failures of probably well-intended but certainly misdirected federal health programs for American Indian tribes.

When the United States Congress passed the original Indian Health Care Improvement Act, P.L. 94–437, it clearly recognized this obligation. S. 277 continues in that tradition. Sections 501 and 502, along with Title I, are very important. They face the problem of the poorest health endured by American Indians today and provide a remedy. Non profit corporations, managed by Indians who reside in the urban community where the corporation is located, is the proper means for meeting the health needs of Indians in those urban communities. The examples of urban Indian health projects in Minneapolis, Minnesota, Seattle, Washington and Milwaukee, Wisconsin encourage Indian communities in all of America's large cities. They need the basic assistance for development that Sections 501 and 502 can provide.

Sections 501 and 502 touch the psychological realm of cross-cultural sensitivity which must always be considered when the federal government deals with American Indians. In the United States where the entire population comes from cultural masses around the world, the members of the indigenous cultures who have always resided in this land deserve sensitive cross-cultural respect.

I support the entire S. 277 bill. However, I choose to limit my observations to the above remarks since I believe that too frequently they are overlooked in the planning of health care programs for American Indians. Other witnesses will address the other sections of S. 277.

I recognize that for the present administration economic efficiency is the most effective argument for support of federal programs. In the highly developed monetary economy that we have in the United States economic efficiency cannot be ignored. We deal with economic issues. In this view we clearly see that cross-cultural sensitivity in federal Indian programs a century ago would have eliminated most of these problems at the end of the twentieth century, and true economic efficiency would have been achieved. Regardless of the economic factors involved now, the essential issue to consider is that the federal government has a moral obligation to meet. The Indians gave up their land when they signed the treaties, the United States gave promises and commitments that still need to be fulfilled.

I urge the passage of S. 277.

Mr. TAYLOR. Thank you very much, Father Zuern.

Our next witness is Myron Thompson from Kamehameha Schools in Honolulu, HI.

Senator INOUYE [acting chairman]. Mr. Chairman and members of the committee, it is my honor to present to you Mr. Myron Thompson, a trustee of the Kamehameha Schools, a very distinguished citizen of the State of Hawaii, an activist when it comes to education and on matters relating to native Hawaiians. I think the committee will learn much from Mr. Thompson.

Welcome, sir.

STATEMENT OF MYRON THOMPSON, TRUSTEE, KAMEHAMEHA SCHOOLS, BISHOP ESTATE, HONOLULU, HI

Mr. THOMPSON. Senator Inouye, I appreciate your presence knowing that you are having difficulty with your foot. We and the people of Hawaii are very appreciative of your coming to this hearing this afternoon.

Ms. Zell and Mr. Taylor, good afternoon.

My name is Myron Thompson. I am a trustee of the Kamehameha Schools of the Bishop Estate. It is an educational institution which was established in 1887 in the State of Hawaii for the fine purpose of educating children of native Hawaiian descent.

I am also here today to represent a consortium of health care providers in the State as well as other concerned Hawaiian organizations.

In the interests of time, I will summarize the summary of my original summary that I sent into the committee.

This afternoon, I wish to review with you the severe health care needs of native Hawaiians, in some respects, quite similar to those of American Indians, and to enlist the support of your committee in providing relief for these needs. I want to emphasize at the outset that it is not our intention to take from the resources which are to be made available to Indians. I will suggest that authorizations be increased proportionate to our request.

In regard to the health care needs of Hawaiians, full documentation of these needs is contained in the Native Hawaiian Educational Assessment Project report which I presented to your committee about a year ago. In fact, it was just about exactly a year ago. Briefly, some of the more telling statistics are as follows:

No. 1, Hawaiians account for a disproportionate percentage of high-risk births. I noted that when Senator Andrews introduced S. 277, he cited concerns about the high rate of Indian infant mortality. Hawaiian babies have similar rates of infant mortality. Hawaiian women also are over-represented in teenage pregnancies, illegitimate and premature births.

No. 2, Hawaiians remain beset by multiple health problems. Also similar to Indians, Hawaiians' life expectancy is significantly shorter, by 5 to 10 years, than that of other ethnic groups in Hawaii. On most of the severe health indicators, such as various forms of cancer and heart disease, Hawaiians are the most at-risk group in the State and, in some cases, in the world.

No. 3, too many Hawaiians perceive themselves as being inferior. A final report we presented to you in March 1984 describes how two centuries of cultural loss for native Hawaiians has caused stress which, in turn, has led to negative personal health, depressions, and poor educational outcomes.

Senator, these are some of the severe problems affecting the Hawaiian people, but I must say that we feel they are solvable. I believe that measures proposed in S. 277 can alleviate some of the Hawaiian health problems in the same way that they are intended to assist the Indians.

My first recommendation, then, is the passage of S. 277. A very high priority for native Hawaiian health care is research. My second recommendation is therefore to retain the directive in S. 277 to conduct a study of the physical and health care needs of native Hawaiians and other native American Pacific islanders.

Third, I recommend inclusion, where appropriate, of native Hawaiians in sections which would serve to meet the severe and already documented health care needs of these people. To repeat my earlier point, authorizations for native Hawaiians and other native American Pacific islanders should be over and above what is to be authorized for Indians.

In summary, our people currently suffer from a wide array of physical and mental health problems similar to those of other native American groups. Attempts to resolve these problems will require the joint efforts of Federal, State, and community organizations, including our own organization.

Senator Inouye and members of the committee, I would like to thank you and the other members for your interest and attention to this matter. I stand ready to answer any of your questions, but before I do, I would like to introduce Dr. Ormond W. Hammond who has put together these statistics on medical needs throughout the State of Hawaii.

Senator **Inouye**. Mr. Chairman, I ask unanimous consent that the statement of Mr. Thompson be made part of the record and, if appropriate, that the report of March 21, 1984 be made part of the record at this point so that we can refer to that.

[The statement and report follow. Testimony resumes on p. 286.]

PREPARED

TESTIMONY

For the Senate Select Committee on Indian Affairs

by:
MYRON B. THOMPSON
Kamehameha Schools/Bishop Estate
Honolulu, Hawai'i

March 6, 1985

Good morning Chairman Andrews and members of the committee.

My name is Myron Thompson. I am a trustee of the Kamehameha Schools/Bishop Estate, an educational institution in Honolulu, established in 1887 for the purpose of educating children of Native Hawaiian descent.

In 1982 I was asked by Secretary of Education Terrel Bell to chair the Executive Steering Committee for the Native Hawaiian Educational Assessment Project (NHEAP). The purpose of this project was to quantify the severity and scope of the educational needs of Native Hawaiians and to determine what could be done to improve the situation. Our Final Report was presented to Secretary Bell in March of 1983. On March 21, 1984, one year ago, I appeared before your committee to present the results of the study.

Although the NHEAP study concentrated on educational needs, it became clear that Native Hawaiians have many severe physical and mental health care needs which are inextricably connected to education. I am here today to review with you some of these severe health care needs of Native Hawaiians, to suggest that these needs are similar to those of Native American Indians, and to enlist the support of your committee in providing relief for these health care needs which is equitable with that available to other Native Americans. Specifically, because I believe that the needs of all Native Americans are severe and immediate, I support S.277, Indian Health Care Improvement Act Amendments of 1985, and I would like to suggest certain additions to the Bill to ensure the equitable treatment of Native Hawaiians.

The Native Hawaiian Educational Assessment Project (NHEAP) Final Report indicated that Native Hawaiian students suffer from an across-the-board lack of parity with their peers nationally. Specifically, the report demonstrated the following major needs:

1. Standardized Achievement Needs. Hawaiian students score below parity with national norms in reading and math, and they are well below the other ethnic groups in Hawaii.

2. Special Educational Needs. Native Hawaiians face a wide array of economic, physical, and mental health problems which affect their academic achievement.

3. Culturally-related Academic Needs. Hawaiians have increasingly become "strangers in their own land" and lost remnants of their values, lifestyle, language, and beliefs. This loss has manifested itself in depression, self-disparagement, and inferior scholastic achievement.

In the Final Report, physical and mental health were further broken down into a number of documentable "conditions." These were as follows:

Physical Health
- Multiple Health Problems
- Maternal-Child Health Indicators
- Nutrition
- Health Care System
- Health Education in the Schools

Mental Health
- Family Stress
- "Fear of Learning"/Depression
- Problems in Childrearing
- Problematic Social Behavior
- School Behavior Problems

Full documentation of the need conditions is contained in the report, and copies of the relevant pages are attached as an Appendix to this testimony. Briefly, some of the more telling statistics are as follows:

I. HAWAIIANS ACCOUNT FOR A DISPROPORTIONATE PERCENTAGE OF HIGH-RISK BIRTHS.

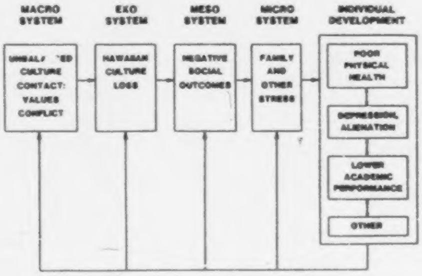
Hawaiian young women aged 11-19 (who account for approximately 25% of that age group) are more likely to become pregnant and to give birth (40%) than are young women of other groups. Other data from the State Department of Health confirm that Hawaiian young women are likely to seek prenatal care later in pregnancy than are other women. Over 30% of all premature births in the State are Hawaiian, and over 50% of all illegitimate premature births. Other signs of family stress abound, including disproportionately high rates of child abuse and neglect. The figures documented in the Native Hawaiian Educational Assessment Project (NHEAP) Final Report have been substantiated by subsequent data. In a December, 1984 report issued by the State Department of Health (Frequency of Reproductive Dysfunction in Hawaii by Race and Judicial District, 1968-1982), Hawaiian mothers were found to have the highest rates of births with congenital defects (11.4 per 1,000), births under 1501 grams (11.9 per 1,000), and neonatal deaths (10.9 per 1,000).

II. HAWAIIANS REMAIN BESET BY MULTIPLE HEALTH PROBLEMS.

On most of the severe health indicators, such as various forms of cancer and heart disease, Hawaiians are the most at-risk group in the state. This is perhaps best indicated by the finding that Hawaiians' life expectancy is significantly shorter (69.9 years) than that of other ethnic groups (others average 77.3 years in recent Department of Health data). Hawaiians' lung cancer rates, for example, are among the highest in the world and exceed those of all other ethnic groups in Hawaii. In a Department of Health study in 1978, Hawaiians were shown to have the worst overall comparative health of any group in the state

III. MANY HAWAIIANS APPARENTLY SUFFER FROM A CULTURE LOSS/STRESS SYNDROME.

The NHEAP Final Report describes how two centuries of culture loss for Native Hawaiians may be linked to negative personal health and educational outcomes through the intermediate mechanism of stress. This is best illustrated by the following figure from the report:


THE CULTURE LOSS/STRESS HYPOTHESIS

MACRO SYSTEM
EXO SYSTEM
MESO SYSTEM
MICRO SYSTEM
INDIVIDUAL DEVELOPMENT
UNBALANCED CULTURE CONTACT: VALUES CONFLICT
HAWAIIAN CULTURE LOSS
NEGATIVE SOCIAL OUTCOMES
FAMILY AND OTHER STRESS
POOR PHYSICAL HEALTH
DEPRESSION, ALIENATION
LOWER ACADEMIC PERFORMANCE
OTHER

The kinds of words which have been used to describe modern Hawaiian youngsters include "self-disparagement," "low self-esteem," "hopelessness," and "alienation."

PROPOSED SOLUTIONS

These are severe problems, both in terms of their human and their economic costs, but they are not irremediable. The key seems to be in prevention. What is needed is a comprehensive approach to prevention. The first priority is research. Why are a disproportionate number of Hawaiians at risk? What effect is played by the stresses associated with the loss of Hawaiian culture over the last two centuries? A detailed assessment is also needed of the level of unmet needs in Hawaiian communities. The second prong is the implementation of effective health education and intervention efforts which should include culturally sensitive methods and the early involvement of health care providers and communities in the prevention and lifestyle change process.

The Indian Health Care Improvement Act of 1976 (P.L. 94-437) and subsequent Amendments to the Act provide major federal assistance to bring the health status of Native American Indians to parity with the rest of the nation. Last year, in bills to amend the Act and in legislation passed by the Senate Appropriations Committee (P.L. 98-396), the Department of Health and Human Services was directed to conduct a comprehensive review of the unique health care needs of Native Hawaiians. The current proposed amendments to the Act retain the directive for the study (Section 718). This assessment will be a major step forward in terms of initiating the research which I am recommending.

Other Native American groups, under the Indian Health Care Improvement Act of 1976, have a source of funding for programs aimed specifically at bringing the health status of Indians to parity with the rest of the nation. Native Hawaiians, being excluded from the Act, have as yet no such assistance. Recently, a similar situation in Vocational Education was rectified by the passage of the Carl D. Perkins Vocational Education Act of 1984. This Act provided set-aside funding for Hawaiian Vocational Education proportionate to what was already targeted for other Native American groups. What is recommended here is the amendment of Indian health care legislation in like manner.

There are several sections of existing legislation which appear to be the most relevant to the identified needs of native Hawaiians and which, through amendment, could significantly reduce inequities which exist between Hawaiians and other Native Americans as well as move Hawaiians closer to health status parity. For example, Title I (Sections 101 - 106) provides for Indian Health Manpower, including the Health Professions Recruitment Program for Indians and Continuing Education Allowances. This could provide the basis for increasing the number of Native Hawaiians who pursue health care professions as well as increasing the sensitivity, awareness, and responsiveness of existing health professionals to Native Hawaiian needs. Titles II (Section 201) and V

(Sections 501-510) actually provide for programs to more directly provide health care, including direct and indirect clinical care, preventive community and other mental health services, dental care, training of traditional Native American practitioners, emergency medical services treatment and control and rehabilitative care related to alcoholism, and accident prevention programs. Provisions are made under Title V for urban Indians by authorizing the Secretary to enter into contracts with urban Indian organizations to assess needs and provide appropriate services.

RECOMMENDED LEGISLATIVE ACTION

It should be emphasized that the U.S. Congress, through various pieces of legislation including most recently the Carl D. Perkins Vocational Education Act, does recognize and treat Native Hawaiians as Native Americans. It would thus be recommended that the name of the Act itself be changed to Native American Health Care Improvement Act. While not specifically covered in this paper, the needs of other Native American Pacific Islanders would thus also be subsumed.

Following the precedent set in the Carl D. Perkins Vocational Education Act of 1984, wording to include Native Hawaiians in a Native American Health Improvement Act, specifically, under Title V, might parallel that in the vocational education legislation:

> ...the Secretary is directed to enter into contracts with organizations primarily serving and representing Hawaiian natives which are recognized by the Governor of the State of Hawaii to plan, conduct, and adnminister programs, or portions thereof, which are authorized by and consistent with the provisions of this section for the benefit of Hawaiian natives." (Section 103-C)

Further, as in the vocational education legislation, the term "Hawaiian native" means:

> "Any individual any of whose ancestors were natives, prior to 1778, of the area which now comprises the State of Hawaii.(Section 103-B)

Allotments for Native Hawaiians should also follow the formula used in the vocational education legislation. In that precedent, of the monies appropriated for Native Americans, Indians received 83.3% and Hawaiians 16.7%. Similarly, then, Hawaiians should receive 16.7% of Health Care Improvement Act funds. Most importantly, the actual amount of appropriations should be increased proportionately so that Native American Indians will still receive the same amount as currently proposed in this bill.

SUMMARY

In summary, Native Hawaiians currently suffer from a wide array of physical and mental health problems similar to those of other Native American groups. Attempts to resolve these problems will require the joint efforts of federal, state, and community groups.

My recommendations here today are as follows:

1. I recommend the passage of S. 277, amended so as to be called Native American Health Care Improvement Act Amendments of 1985.

2. I support the inclusion of the directive to conduct a study of the physical and health care needs of Native Hawaiians and other Native American Pacific Islanders (Section 718).

3. I recommend the immediate inclusion, where appropriate, of Native Hawaiians in sections where programs may be conducted which would serve to meet the severe and already-documented health care needs of Native Hawaiians. Initially, therse programs should complement the necessary needs assessment research called for in Section 718.

4. Ultimately, Native Hawaiians should be an integral part of the Native American Health Care Improvement Act, following the precedents set in the Carl D. Perkins Vocational Education Act and other recent federal legislation which recognizes Hawaiians as Native Americans.

Chairman Andrews, I would like to thank you and the other members of your committee for your interest and attention to this matter. I want to assure you that the Kamehameha Schools/Bishop Estate stands ready to fully participate, along with our sister agencies at the state and local level, in all efforts for the benefit of Native Hawaiians. My colleagues and I remain convinced that, through these kinds of joint efforts, Native Hawaiians will be completely successful at overcoming their current problems. I will be happy to answer any questions you may have.

Major Need Category: Special Educational Needs

General Need Area: Physical Health

Condition 1: Multiple Health Problems

Condition Summary

A range of health concerns are indicated by relatively low life expectancy, overrepresentation among victims of specific diseases (e.g., diabetes), high incidence of cancer and hypertension, etc.

Potential Educational Interventions

- School health education programs.
- Condition-specific preventive health education for school-age youth.
- School-based support services to families in which health problems interfere with educational activities of youth.

Testimony

If the claims of some health professionals that life-stress events are highly correlated with incidence of diseases of many types are true, then the general health record of Hawaiians is certainly an indication of high life stress: their health is clearly the poorest of any ethnic group in the state.

The litany of health problems of Native Hawaiians has been concisely summarized by Winona Rubin (1980), Executive Director of Alu Like, Inc., the non-profit agency that has maintained extensive files of social indicator data related to Hawaiians:

> Native Hawaiians do not fare as well as other ethnic groups in the state by many health indicators. Native Hawaiians have higher than average physical health problems for chronic conditions such as cancer, diabetes, gout, coronary heart diseases, dental health, and child and family nutrition. Self-reports of health conditions, such as days in bed, hospital visits and time lost from work are comparable with all other groups; however, Native Hawaiians in all age groups have higher death rates than most other groups. The Native Hawaiian's life expectancy at birth is shorter than the state average by six to seven years.
>
> The quality of health for older Native Hawaiians is also dismal. Approximately 25 percent of elderly Native Hawaiians age 65 years or more have either not registered for Medicare or are not enrolled in a health care program. Many elderly Native Hawaiians continue to make use of traditional spiritual and folk remedies. Professional help might be sought after traditional remedies have been exhausted, and then only if the health care provider's relationship is on a one to one basis.
>
> The poor health and income of elderly Native Hawaiians leave them especially vulnerable to high health care costs and inadequate health services. (Hawaii Advisory Committee to U. S. Comission on Civil Rights, 1980)

In a similar more recent summary Thompson and Hannahs (1979) added three infancy indicators: congenital malformations, prematurity, and infant birth complications. Other than these their order of presentation and the points considered echo Rubin's:

> Compared with other adults statewide, the Hawaiian-ancestry population also does not fare as well on indicators of health. Data on specific chronic conditions such as cancer, diabetes, gout, high-blood pressure, congenital malformations, prematurity, infant birth complications show that rates for these conditions among those with Hawaiian ancestry are higher than that for the State population. Furthermore, death rates at all ages are higher for the Hawaiians. The East-West Population Institute projects that the life expectancy at birth is shorter by almost a decade for those with Hawaiian ancestry than that for all ethnic groups in the State. (p. 6)

On the issue of cancer a recent account of the Cancer Center of Hawaii's Tenth Anniversary provided the following summary statements regarding their epidemiological work of the past decade:

> —Lung cancer rates for Hawaiians and part-Hawaiians are among the highest in the world and exceed those of all other ethnic groups in Hawaii.
>
> —Although women in general have less chance of developing lung cancer than men, Hawaiian women actually have higher rates of lung cancer than do Japanese, Chinese or Filipino men.
>
> —Both Hawaiians and Japanese have very high rates of stomach cancer.
>
> —Breast cancer is most common among both Hawaiians and Caucasians. It occurs much less among Japanese and Chinese and even less among Filipino women. (*Honolulu Star-Bulletin* May 24, 1982)

Social Indicator Data

The Hawaii State Department of Health occasionally uses data gathered in its Health Surveillance Program as a means of studying the health, demographic, and socioeconomic characteristics of the population of the State. Burch (1978), a study of ethnicity and health in Hawaii for 1975, is an example of the type of work that has periodically been completed. In brief, rates per 1,000 population for eleven key health indices were computed for each of the five major ethnic groups in Hawaii (Caucasian, Chinese, Filipino, Hawaiian/Part-Hawaiian, and Japanese) and for a sixth "Others" group. The data presented in Table 22 shows the highest and second highest ethnic groups in terms of incidence for each of the 11 health indices. Hawaiians clearly appear more regularly than any other group, a point Burch noted in his concluding statement:

> The Hawaiian/part-Hawaiian ethnic group had the highest or next highest rate for all health indices studies except for tuberculosis and cerebrovascular disease, and the Caucasians had the highest or next highest rate for all health indices

> except diabetes, tuberculosis, hypertension and cerebrovascular disease. In contradistinction, the Chinese had the lowest or next to the lowest rate in seven of the eleven health indices and the highest only in cerebrovascular disease. The Japanese had next to the highest rates in diabetes, tuberculosis and hypertension, and the third highest in individuals with one or more chronic conditions, but in all else they were lowest or next to the lowest. Filipinos had the highest rate of tuberculosis and the lowest rate of arthritis and rheumatism. In all other categories, their rates were intermediate . . . The comparative health, from best to poorest, of the ethnic groups studied based on the summations of the rankings were: Chinese, Japanese, Filipino, Caucasian, and Hawaiian/part-Hawaiian. (Burch 1978, p. 2)

TABLE 22

Rate Per 1000 of the Top Two Ethnic Groups for Various Health Indices, 1974-1976[1]

	1. Highest Case Rate		2. Second Highest Case Rate	
Major Health Indices	**Ethnic Group**	**Rate Per 1000**	**Ethnic Group**	**Rate Per 1000**
One or more Chronic conditions	Other	679.5	Hawaiian	374.9
One or more bed days	Hawaiian	82.7	Caucasian	81.0
One or more Hospital nights	Caucasian	82.1	Hawaiian	73.0
Back impairment	Hawaiian	43.0	Caucasian	38.8
Visual impairment	Caucasian	13.2	Hawaiian	12.5
Arthritics/Rheumatism	Caucasian	39.4	Hawaiian	27.7
Diabetes	Hawaiian	33.7	Other	27.0
Tuberculosis	Filipino	7.2	Hawaiian	2.0
Heart Disease	Other	21.1	Hawaiian	19.7
Hypertension	Hawaiian	71.8	Caucasian	49.0
Cerebrovascular Disease	Chinese	5.2	Other	3.4

[1] Ethnic groups included five major local groups: Caucasian, Chinese, Filipino, Hawaiian/Part-Hawaiian, and Japanese, as well as a catch-all "Others" group.

Source: Burch, 1978, pp. 1-6.

Of the rates shown in Table 22 one of the most marked contrasts between the highest and second highest rates of occurrence was for hypertension. Hawaiians substantially outpaced second place Caucasians. This, along with the figures for heart disease, may be of particular interest in light of recent reports on the decline in the U. S. in mortality due to heart disease. Specifically, Levy and Moskowitz (1982) recently reported findings which show a 30 percent decline in mortality due to heart disease during the past 30 years. Moreover, they noted that over 60 percent of this decline occurred between 1970 and 1980.

However, in the midst of this downward trend it can be noted that Hawaii dramatically changed its relative standing between 1968 and 1978. That is, from a rank of 50th in the U.S. with the lowest mortality rate due to coronary heart disease (for total population aged 35-75) Hawaii moved to 18th, well into the middle of the pack with respect to this undesireable indicator. This degree of change in relative standing appears to be the largest of any state in the country for the time period considered.

Perhaps even more striking than the incidence rates for major health indicators are the estimated life expectancies at birth of major ethnic groups in Hawaii. Schwitters (1981) offered the data presented in Table 23, which in turn were drawn from Gardner (1980). It can be seen that Hawaiians have gradually been closing the gap between themselves and the four other major ethnic groups; however, a sizeable gap remains with Hawaiians having the lowest life expectancy of any of the major groups in the State. The only exception was in 1920 when Filipinos fell below Hawaiians. This alignment had changed by 1930, though, and since then Hawaiians have consistently shown the lowest life expectancy.

Finally, a very recent study of mortality rates among Hawaiians and part-Hawaiians showed remarkable differences in death rates between the two groups (Look, 1982). In general, it was found that part-Hawaiians were by-and-large very comparable with state

TABLE 23

Estimated Life Expectancy at Birth by Ethnicity, 1910 - 1970

	Caucasian	Chinese	Filipino	Hawaiian Part-Hawaiian	Japanese	Other[1]	Total	Range[2]
1910	52.90	56.36	N/A	30.28	49.09	10.59	43.61	26.08
1920	57.02	54.75	32.95	35.03	51.22	28.95	46.91	24.07
1930	62.39	59.60	49.88	42.92	59.89	35.40	54.82	19.47
1940	64.91	65.05	62.92	52.35	67.46	53.99	62.84	15.11
1950	69.64	69.82	69.74	62.64	72.57	67.63	69.63	9.93
1960	72.78	73.83	71.64	64.94	75.55	62.72	72.32	10.61
1970	73.19	76.10	71.79	67.46	77.30	76.88	73.97	9.84
Male	70.68	74.78	70.21	65.05	75.71	75.25	72.03	10.66
Female	76.04	77.50	75.54	69.91	78.93	78.39	76.37	9.02

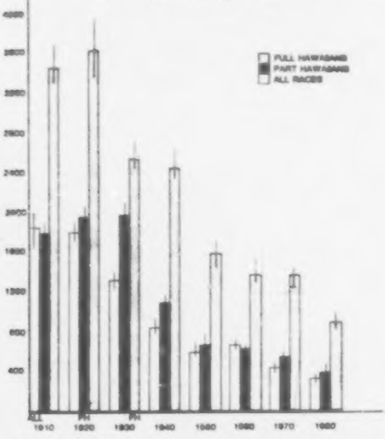
[1] The 1910 tables for all ethnicities and the "Other" tables for all years should be viewed skeptically

[2] Highest minus lowest expectancy; excludes "Other."

Source: Gardner, 1980, no 9, pp. 221-226. Cited in Schwitters, 1981

FIGURE 27

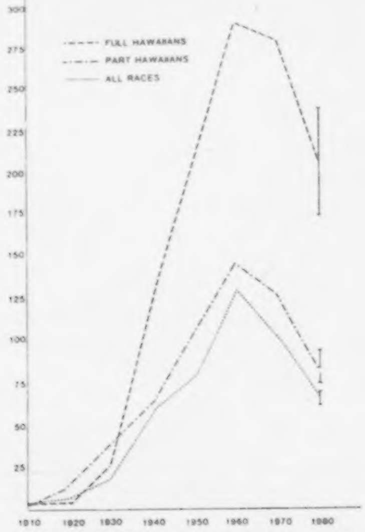
Cause of Death:
All Causes by Standardized Rates
Per 100,000 Pop. 95% cl



Source: LOOK, 1982, p. 8

FIGURE 28

Cause of Death:
Arteriosclerotic Heart Disease by
Standardized Rates Per 100,000 Pop.



Source: LOOK, 1982, p. 14

totals overall, while rates for Hawaiians were substantially higher in almost all cases. Figure 27 shows the extent of these differences across 20th century census years for all causes of death combined. It can be seen that Hawaiians have been dying at substantially higher rates per 100,000 population than part-Hawaiians or than residents of the state as a whole.

In recent years, death rate discrepancies have been most notable for diseases which have become the leading causes of death as other causes (e.g., pneumonia) have declined in significance due to medical and health care advances. These continuing threats to life include: arteriosclerotic heart disease, hypertensive heart disease, cancer, and diabetes mellitus—as well as death due to accidents. Figure 28 shows death rates for the three groups considered in the study with respect to one of these conditions, arteriosclerotic heart disease. Since the graph displayed is exemplary of others in the report, it appears that health may be a much more significant problem for full-Hawaiians than for part-Hawaiians. Indeed, the differences between the two subgroups are so marked that it seems probable that merging Hawaiians and part-Hawaiians in analyses of health conditions may result in an overly negative picture for the latter.

Major Need Category: Special Educational Needs

General Need Area: Physical Health

Condition 2: Maternal-Child Health Indicators

Condition Summary

Health statistics show disproportionately high rates of less than optimal prenatal care, illegitimate births, teenage pregnancy and births, congenital anomalies, and infant deaths.

Potential Educational Interventions

- Special programming and support services for expectant teens and very young mothers.
- Family life education or education for parenting programs.
- Preventive health education in the area of childbearing and childrearing.

Testimony

While all maternal-child health indicators are central to planning educational services for families with very young children (e.g., birth - 3 years), teenage pregnancy and birth statistics, in the wake of recent national attention regarding this "epidemic," tend to grab most headlines.

In Hawaii the issue of teenage pregnancy tends to be somewhat sensitive due to cultural differences between various ethnic groups in their acceptance of out-of-wedlock births to young, school-age couples. For example, Klum (1982) recently reported on the work of Marta Levitt-Merin, an anthropologist and coordinator of the Teen Pregnancy Project in Honolulu, as follows:

> Teenage pregnancy in Hawaii is a social problem with cultural overtones.
>
> Its occurrence in higher rates among some ethnic groups is the subject of a report prepared recently for the Office of Hawaiian Affairs by a federally funded program trying to reduce unwanted pregnancies . . . Levitt-Merin said teenage pregnancy is 'more unacceptable' among the families and peers of Caucasian and Oriental girls than among the other groups. She said there is more pressure on Caucasian and Oriental girls not to carry their pregnancies to term, which explains why they are much more likely to have abortions than girls in the Pacific island ethnic groups.
>
> Hawaiian, Samoan and Filipino families do not encourage their teenagers to get pregnant, Levitt-Merin said, but they tend to be more understanding if pregnancy occurs.
>
> 'Once the girl is pregnant, they will accept the baby into their homes,' she said.
>
> But the recent rise in the abortion rate for teenagers of Hawaiian and part-Hawaiian extraction indicates that more girls in the group are finding abortion an acceptable way of dealing with unwanted pregnancy, she said. (Klum, 1982)

Regardless of changing attitudes which may or may not be occuring among young Hawaiian women, the problem of teenage pregnancy and birth is one that tends to be viewed very differently as a function of one's point of view. The medical profession, for example, is explicit in its view that pregnancy and birth at a young age is undesirable. For instance, key medical personnel from Kapiolani/Children's Medical Center in Honolulu recently offered the following comments on the issue of teenage pregnancy in memoranda sent to the March of Dimes in support of a Teen Intervention Program (March of Dimes, 1982):

> Teenage pregnancy is a major problem in our state. Although they are only 15-20% of all deliveries, they constitute a much higher percentage of pregnancy complications, prematurity and other defects. They constitute one of the highest risk groups of patients in obstetrics . . . (Ralph W. Hale, M. D.; Chief Department of Ob-Gyn, KCMC)

> Kapiolani Hospital is the only civilian tertiary care facility in the state. As a result, we see many of the complications of pregnancy. One of the major contributors to these complications is teenage pregnancy. These patients have the highest percentage of complications for any age group in our hospital. These patients are also the most difficult for the physician to treat. They frequently ignore the physicians' advice and thus incur unnecessary complications which result in premature or damaged infants. . . (George Shimomura, M. D.; Chief of Staff, KCMC)
>
> Any reduction in teenage pregnancies serves to reduce the possibility of high risk pregnancies which can increase the prenatal and hospital costs from $1,300.00 (for a normal pregnancy), to as much as $25,000 . . . (James B. MacMillan, III, M. D., Medical Director, KCMC Adult Outpatient Clinic)

This unequivocal stance contrasts with perspectives on the part of teenagers themselves, who apparently are much more intentional about getting pregnant than one might expect. This point was brought out in Klum's (1982) summary of a report on teenage pregnancy in Hawaii:

> But most teenage pregnancies are intentional—or at least not wholly accidental—according to Levitt-Merin. She said teen pregnancies tend to be a symptom of much deeper problems in the family.
>
> Some teenagers don't use contraceptives to add an element of 'risk-taking' to their sexual relations, she said. Some girls try to get pregnant to create a stronger bond between themselves and their boyfriends. Still others have children because they are looking for someone to love and think a baby would fill that need.
>
> Many girls who get pregnant, Levitt-Merin said, do so in an effort to get their parents to 'listen' to them—to get some attention from their families.
>
> 'The sad thing is, the parents do listen,' she said. 'They listen afterward.'
>
> Levitt-Merin said getting parents to listen to their children would do much to help curb teenage pregnancies, perhaps as much as contraceptive information and sex education programs.

A similar discovery was made by The Kamehameha Schools/Bernice Pauahi Bishop Estate's Kupulani project when a videotaped roundtable discussion involving six teenage Hawaiian mothers revealed that they tended to view pregnancy and motherhood while in high school as a positive, desirable event—something that other young women might be hoping for—rather than as a mistake or a problem. (Kupulani, 1979).

Whether pregnancy and birth at a young age is a meaningful and important dimension of Hawaiian culture, and hence might be considered worthy of preservation and special support, remains an open question for Hawaiians themselves to decide. In the meantime educators are faced with the reality that many young women who get pregnant do not finish their high school educations; plus, there is increasing indication that women who start families early may be more likely to have children who experience problems in their early schooling years (e.g., Kellam, Adams, Brown, & Ensminger, **in press**; Kellam, Ensminger, & Turner, 1977). These realities both have implications for educators: on the one hand young mothers may be in need of specialized education that enables them to complete their schooling if they so desire; while their infants might be considered to be in special need of early childhood education in the years prior to entry into the formal educational system (e.g., birth - 5 years).

Social Indicator Data

Evaluation of maternal and child health happens to be one of the areas in which numerous social indicators have gained widespread acceptance. For example the following newspaper summary shows the type of information that can be presented to the public for their consideration. Clearly, the intent of such an analysis is to determine the extent of a "problem." In this instance it would appear that Hawaiians present a significant social problem by virtue of their comparatively high rates of teenage pregnancy. This may or may not be the case. In the meantime this summary of social indicator information serves as introduction to the types of analyses possible using vital statistics information.

> According to data collected by the department [of Health], the Hawaiian and part-Hawaiian ethnic group has the

highest teenage pregnancy rate — followed closely by the Samoan and Filipino groups. The levels are double the rate for Caucasians and triple the rates for Japanese and Chinese.

The rates for the 15-to-17 age group, in pregnancies per 1,000, are: Hawaiians/part-Hawaiians, 78.2; Samoans, 74.2; Filipinos, 71.2; Caucasians, 37.0; Japanese, 24.6; and Chinese, 23.7.

Hawaiian and part-Hawaiian girls represent 18.9 percent of the overall population in the 15-to-17 age group. But they produce 34.1 percent of the pregnancies and 44.3 percent of the births in that age category. (Klum, 1982)

The Kamehameha Schools/Bernice Pauahi Bishop Estate recently made extensive use of vital statistics data in carrying out a needs assessment with respect to Hawaiian children from birth to age three (Office of Program Evaluation and Planning, 1980, Report No. 80-81:26). In brief, this study reported that the most convenient indices to use in defining educational need for very young children were three areas of maternal and child health: teenage pregnancy, prenatal care, and birth outcomes; along with information about child abuse and neglect. Since the analyses in this report are of the same type included in this study we are reprinting the sections of our earlier report which deal with the three maternal and child health indicators, an analysis of risk factor interrelationships at the community level, the summary and conclusions from the report, and a final summary of needs, goals, and "most-in-need" groups.

RISK FACTORS

I. The Teenage Pregnancy Factor

The first **risk area** concerns early pregnancy. There is an extensive literature on the reasons for teenage pregnancy and the effects of the phenomenon on both the mother and the baby. (For a recent review, see Bolton, Frank G., *The Pregnant Adolescent: Problems of Premature Parenthood.* Beverly Hills: Sage, 1980) The nation as a whole has been experiencing an increase in younger pregnancies, partly because of the increase in numbers of adolescents, but partly due to a complex set of sociopsychological factors which are only dimly understood by researchers (Chilman, 1979).

The correlational risk factors are clear; there is a higher association of young pregnancy with the following kinds of negative outcomes for the baby:

- Higher rates of infant mortality;
- Higher rates of birth defects;
- Higher rates of mental retardation and reduced intelligence;
- Higher rates of prematurity and low birthweights (Bolton, 1980).

For the young parent, too, the risks to optimal development are clear:

- Reduced chances of finishing school (Ewer and Gibbs, 1976);
- More dependency on social welfare and public assistance;
- Higher rates of early marriage and separation and divorce;
- Lower earnings from employment (Chilman, 1979).

It is important to note that negative outcomes are intimately connected to what may be the causal determinants of the phenomenon. Early pregnancies have been found to occur more frequently in women who are **already** experiencing negative outcomes in their own lives: familial stress, educational problems, low income, poor nutritional habits. In other words, it is a cyclical kind of thing with no one set of simple causes.

Two recent studies of adolescent fertility in Hawaii found much the same patterns here and indicated that the risk factors were particularly severe for Hawaiians. One, a study of unintended pregnancy in the Windward District (Yates, 1980) included the following findings:

- 29.9% of the high school students have had sexual intercourse; 66.7% have not.
- 9.2% of the intermediate school students have had sexual intercourse; 89.2% have not.
- 31% of the sexually active students have had sexual intercourse by age 14.
- 3% of the sexually active population said they wanted a baby at this time, but 65% never use birth control.
- 77% of the reported pregnancies in the Windward District may be said to be unintended.

TABLE 24

Number and Percentage of Hawaiian Mothers in 11 - 19 Year Old Age Range, 1974 - 1978

Year	Total # Live Births	Live Births To Mothers 11-19	Percent	Total # Live Births To Hawaiian Mothers	Live Births to Hawaiian Mothers 11-19	Percent	Hawaiian % of Live Births To Mothers 11-19
1978	16,717	2,090	12.5	3,630	810	22.3	38.8
1977	16,874	2,159	12.8	3,667	770	21.0	35.7
1976	16,292	2,205	13.5	3,465	803	23.2	36.4
1975	15,689	2,228	14.2	3,302	793	24.0	35.6
1974	15,472	2,276	14.7	3,262	772	23.7	33.9

Surveying statistics from 1968-1972, another study (Stringfellow, Wooton, Hustace, Burch, Reyes, and Colby, 1978) found that the highest rate of pregnancies among adolescents aged 11-19 was among the Hawaiian group (34.0%). The trend was even more pronounced among the very young, 11-14: 58 births, or 46.0%. The study also reported that Hawaiians had the highest number of premature births and the second highest rate of infant deaths.

Table 24 shows that for each of the years 1974-1978 the percentage of young (11-19 year old) mothers giving birth was higher for Hawaiians than is their percentage in the general population. In one representative year, 1976, the percentage of Hawaiian young women ages 10-19 in the general population was 25.8%. While a larger number than the overall 17.7%, it is still below the percentage of mothers giving birth at an early age.

This trend is even more marked for the **very** young group, 11-14 years old. Table 25 shows that most of these births have been to Hawaiian women during the 1974-1978 period.

TABLE 25

Number and Percentage of Hawaiian Mothers in 11 - 14 Age Group, 1974 - 1978

Year	Total # Live Births To Mothers 11-14 Yrs. Old	# Live Births To Hawaiian Mothers 11-14	Hawaiian % of Live Births To Mothers 11-14
1978	20	14	70.0
1977	20	11	55.0
1976	16	8	50.0
1975	34	22	64.7
1974	26	10	38.5

Table 26 demonstrates how high the percentage of illegitimate births has been to young Hawaiian mothers in the 1974-1978 period. Approximately **half** of all the illegitimate births to women 11-19 years old were to Hawaiian mothers.

TABLE 26

Number and Percentage of Illegitimate Births to Hawaiian Women in 11-19 Age Group, 1974 - 1978

Year	Total # Illegitimate Births To Women 11-19	# Illegitimate Births To Hawaiian Women 11-19	Hawaiian % of Illegitimate Births To Women 11-19
1978	996	516	51.8
1977	981	469	47.8
1976	869	444	51.1
1975	848	441	52.0
1974	772	397	51.4

Some have argued that legitimacy in and of itself should not be considered a risk factor in the Hawaiian community since birth out of wedlock is more culturally acceptable (Cohn, 1980; Gallimore and Howard, 1968). When combined with teenage pregnancy, however, illegitimacy at the least implies a strained *'ohana.*

In conclusion, in terms of both age of mother and the legitimacy factor, indications are that some Hawaiian young women are at risk, and that this has been a stable trend over time. It shows no signs of changing. There were an average of 439 illegitimate births to Hawaiian teenage women during the five-year period 1974-1978. An average of 13 births each year were to Hawaiian girls 11-14 years old. The other risk factors which might be expected to go along with this trend will be considered separately in the following sections.

II. The Prenatal Care Factor

Another general area of risk is in prenatal care. During pregnancy the mother must provide the entire environment in which the developing baby will grow. What the pregnant woman eats, drinks, and smokes, as well as how she cares for herself physically and mentally, play an important role in prenatal development. Many of the risks of this period are of an individualistic, interactive sort (Kopp and Parmelee, 1979). That is, complex factors involving the vulnerability of the stage of fetal development, maternal genetic factors, and the type of disruptive events make it difficult to determine if there are universal dangers. Certain women are apparently more susceptible to toxemia, for example, and must restrict their diet. What this implies is that regular, thorough medical attention beginning early in pregnancy is the best bet for reducing individual risk. Early, regular medical care has become the theme for the March of Dimes in its national campaign, and there is evidence that intervention programs do effectuate positive outcomes as determined by state of health of mother and baby at birth (Wexler, 1979).

As shown in Table 27, a disproportionately large percentage of Hawaiian women report receiving no prenatal care at all. From 27.1% to 35.3% of mothers not receiving prenatal care have been Hawaiian mothers.

In addition, a smaller than proportionate percentage of Hawaiian women giving birth in these years began receiving prenatal care in the first three months of pregnancy, when medical attention is of key importance (Table 28). These profiles indicate that there is much room for improvement: that many Hawaiian mothers are not receiving adequate and easily accessible care.

TABLE 27

Number and Percentage of Hawaiian Mothers Receiving No Prenatal Care, 1974 - 1978

Year	Total # Live Births	# Mothers Receiving No Prenatal Care	Percent	Total # Births To Hawaiian Mothers	# Hawaiian Mothers Receiving No Prenatal Care	Percent	Hawaiian % of Mothers Receiving No Prenatal Care
1978	16,717	201	1.2	3,630	71	2.0	35.3
1977	16,874	244	1.4	3,667	71	1.9	29.9
1976	16,292	162	1.0	3,465	45	1.3	27.8
1975*	15,689	620	4.0	3,302	182	5.5	29.4
1974*	15,472	543	3.5	3,262	147	4.5	27.1

*Data for 1974 and 1975 lumped "no prenatal care" with "no answer recorded."

TABLE 28

Number and Percentage of Hawaiian Mothers Receiving Prenatal Care Late, e.g., After First 3 Months, 1974 - 1978

	Total # Live Births	# Mothers Receiving Prenatal Care After 1st 3 Mos.	Percent	# Live Births Hawaiian Mothers	# Hawaiian Mothers Receiving Prenatal Care After 1st 3 Mos.	Percent	Hawaiian % of Mothers Receiving Prenatal Care After 1st 3 Mos.
1978	16,717	4,741	28.4	3,630	1,317	36.3	27.8
1977	16,874	5,024	29.8	3,667	1,352	36.9	26.9
1976	16,292	4,824	29.6	3,465	1,285	37.1	26.6
1975	15,689	5,035	32.1	3,302	1,355	41.0	26.9
1974	15,472	4,757	30.7	3,262	1,323	40.6	27.8

The last stage during which prenatal care is available is labor and delivery. While it has become increasingly popular in recent years to plan for birth at home, by far the majority of births are in hospitals, where prompt medical attention is at hand for emergencies. Table 29 shows that Hawaiian babies are **not** disproportionately being born away from trained care (including physicians and midwives). The low percentages of Hawaiian babies born with no attendant is apparently due to the overwhelming majority of such babies coming from the Caucasian group. It is interesting to note, however, that in the years of the study the percentages of unattended Hawaiian births has increased while that of the Caucasian group has not.

TABLE 29

Number and Percentage of Hawaiian Babies Being Born Without Medical or Other Attendant, 1974-1978

Year	Total # Births With No Attendant	No. Hawaiian Births With No Attendant	Percent	No. Caucasian Births With No Attendant	Percent
1978	153	18	11.8	108	70.6
1977	147	24	16.3	103	70.1
1976	126	11	8.7	96	76.2
1975	86	6	7.0	64	74.4
1974	77	3	3.9	66	85.7

III. The Birth Indicators Factors

The events of birth itself give the "outside" world the first chance to assess the health and status of the new baby. Certain of these events are considered risk indicators, predictive of later developmental problems. Certain others are negative outcomes in themselves. Infant death and congenital malformation are obvious examples of the latter category. Low birthweight, or prematurity, is an example of a condition associated with later problems as well as being the source of immediate distress and need for medical attention (Schwartz and Schwartz, 1977). In fact, prematurity, or low birthweight, has become the center of controversy in an area of the field of bioethics: medical science now has the technology available to save the lives of infants who might at one time have perished. Having saved the life, however, the medical profession has little or no technology available to assist the mother and the family cope with the strains and problems which often accompany prematurity. Premature infants thus may later become the victims of familial stress and even abuse and neglect (Schwartz and Schwartz, 1977).

The Department of Health defines prematurity as birthweight of less than 2,500 grams. Table 10 shows that the rate for low birthweight among Hawaiian babies is higher than for the population as a whole, and that this has been true for all but one year of the study. In addition, Table 10 shows that this trend is even more significant for illegitimate births, a factor also associated with early pregnancy as we have seen in the preceding section.

The types of malformations which are recorded in Department of Health figures include cleft palate and harelip, spina bifida:

TABLE 30

Prematurity (Low Birthweight) by "Race" of Baby 1974-1978

Year	Total # Live Births	Number Premature* Births	Percent	Total # Hawaiian Births	No. Hawaiians Premature Births	Percent	Hawaiian % of Premature Births	No. Illegitimate Premature Births	Percent (All Live Births)	Hawaiian Illegitimate Premature Births	Percent (All Hawaiian Live Births)	Hawaiian % of Illegitimate Premature Births
1978	16,717	1,244	7.4	5,054	400	7.9	32.2	269	1.6	137	2.7	50.9
1977	16,874	1,266	7.5	5,060	388	7.7	30.6	248	1.5	130	2.6	52.4
1976	16,292	1,178	7.2	4,750	339	7.1	28.8	197	1.2	91	1.9	46.2
1975	15,689	1,223	7.8	4,518	362	8.0	29.6	191	1.2	93	2.1	48.7
1974	15,472	1,205	7.8	4,405	397	9.0	32.9	208	1.3	105	2.4	50.5

*Less than 2,500 grams

meningocele, hydrocephalus, Down's Syndrome, and other malformations of specific body parts. Table 31 traces the history of malformations 1974-1978 by "race" of the mother. Again, the rate is slightly elevated for Hawaiian mothers for all but one year of the study.

TABLE 31

Congenital Malformations by "Race" of Mother, 1974-1978

Years	Total # Live Births	Births With One or More Congenital Malformations	Percent	Birth To Hawaiian Mothers	Births With One or More Congenital Malformations To Hawaiian Mothers	Percent	Hawaiian Mother % of Births With One or More Congenital Malformations
1978	16,717	155	.9	3,630	40	1.1	25.8
1977	16,874	142	.8	3,667	34	.9	23.9
1976	16,292	153	.9	3,465	30	.9	19.6
1975	15,689	161	1.0	3,302	45	1.4	28.0
1974	15,472	221	1.4	3,262	56	1.7	25.3

Table 32 shows that the rates of infant mortality have been elevated during certain years.

While not always a disproportionate percentage, the number of infant deaths of Hawaiian babies is the highest of any group, and has been for the five years of the study. This is apparently because the Caucasian and Japanese groups have disproportionately low rates of infant mortality, while Filipino, Puerto Rican, and Samoan have disproportionately higher rates.

In summary, there is cause for concern among the indicators of risk at birth. While not consistently disproportionately high, the chances for premature birth, the chances for congenital malformation, and the chances for infant death are all higher for Hawaiians than they should be. As with other "risk" areas, it is not possible to set an absolute standard or acceptable limits, but these data do provide a baseline.

RISK FACTOR INTERRELATIONSHIP AT THE COMMUNITY LEVEL

Thus far a series of "risk indicators" have been examined in terms of whether the data indicate a disproportionate representation among the Hawaiian population. This approach gives a "profile" and baseline for evaluation of program outcomes, similar to the kind of profiles produced by the analyses of standardized achievement test scores for school-age children. These data paint a gloomy picture, however, and they by themselves do not define **who** needs **what kind** of program **where**. One important question that these data cannot address is how the different risk factors interrelate, or, even more importantly, what causes them? While the causal question will remain unanswered for some time, until research methods are equal to the task, there are ways to ask about interrelationships of variables.

In a recent Department of Health report (Cohn, 1980), a comparison is made between

TABLE 32

Infant Mortality 1974-1978

Year	Total # Births	No. Infant Deaths	Percent	No. Hawaiian Births	No. Hawaiian Infant Deaths	Percent	Hawaiian % of All Infant Deaths
1978	16,717	186	1.1	5,054	70	1.4	37.6
1977	16,874	196	1.2	5,060	62	1.2	31.6
1976	16,292	172	1.1	4,750	55	1.2	32.0
1975	15,689	201	1.3	4,518	56	1.2	27.9
1974	15,472	236	1.5	4,405	77	1.7	32.6

three communities on Oahu with respect to differential fertility. The relevance of this study to the present report is that one of the communities, Waianae, is demographically heavily Hawaiian populated, and is widely regarded as a "Hawaiian place." On the other hand, the other two communities studied, Pearl City and Kailua also have a Hawaiian population. The study looks at how a series of variables interrelate. It is emphasized that this kind of comparison cannot establish causal relationships, only suggest variables that covary.

The thrust of the study was to identify factors which relate to the finding that Waianae has the highest crude birth rate (25.7 births per 1,000 population) of the three communities; next is Pearl City (19.5 per 1,000), and Kailua is lowest (14.8 per 1,000).

Table 33 lists all the variables examined in the study and their relative values. These were compared in the study to the crude birth rate. Thus, it was concluded that there is a **negative** relationship between fertility and level of educational attainment, income, level of professional employment, rate of abortions, and percentage of the population Japanese and Caucasian. There was a **positive** relationship between fertility and household size, rate of illegitimate births, unemployment, and percentage of the population Filipino and Hawaiian. The ethnicity findings are not as clear-cut as they may sound. They are based on lumping together the above groups. When the three communities are examined only in terms of the Hawaiian population, the following nonlinear pattern emerges (See Figure 29):

It may be seen that Kailua, with the lowest crude birth rate, does **not** have the lowest percent Hawaiian population; it has a percent (22.0%) slightly **above** the State average percentage (17.7%).

One explanation offered is that the Hawaiians living in Kailua are a part of a community culture which is different from the other two areas. They may be more successful in the terms of the contemporary society, thus have lower fertility levels.

The higher fertility rate in Waianae is interpreted by the author of the study to reflect the socio-cultural context of the Waianae coast. It is suggested that the value of children in the

TABLE 33

Listing of Values For Variables, Community Study (Cohn, 1980)

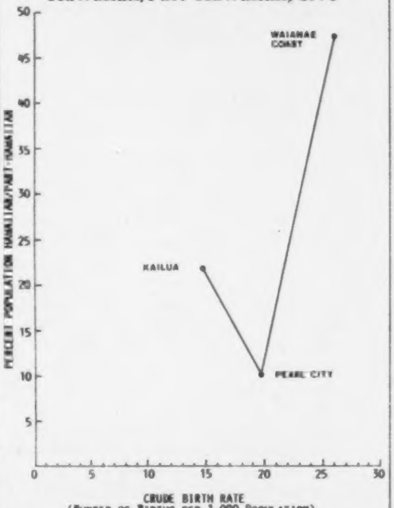
	Hawai'i	**Pearl City**	**Waianae Coast**	**Kailua**
Crude Birth Rate*	18.3	19.5	25.7	14.8
Abortions per 1000 births+	260.3	211.6	133.4	304.3
Illegitimate births (%)*	10.9	6.7	19.3	9.2
Percent population with 8th grade education or less (16+)	11.9	7.5	18.9	4.7
Percent with households with 7 or more	6.0	3.7	16.6	3.5
Percent employed professional	30.8	29.2	20.4	40.8
Percent employed laborer	10.2	12.4	21.9	9.5
Percent employed farmer	1.8	.5	9.7	.4
Population 16+ unemployed	7.5	7.6	11.9	7.2
Percent population Caucasian	27.9	20.6	11.4	49.9
Percent population Chinese	5.6	2.3	.5	2.2
Percent population Filipino	10.2	8.7	11.8	1.7
Percent population Hawaiian (part/Haw'n)	15.3	10.4	47.5	22.0
Percent population mixed/other	9.6	11.9	12.6	6.4
Percent population separated/divorced	3.7	1.6	6.0	3.4
Percent population married	62.4	65.7	58.4	65.0
Percent households below poverty level	10.0	2.2	19.9	7.2
Median income (thousands $)	14.1	18.7	12.6	19.8

* Three-year average from Health Cooperative Statistics System
+1974 State of Hawaii Vital Statistics

Sources: All data from OEO 1975 Census Update Survey Oahu unless noted otherwise.

FIGURE 29

Fertility and Percent Population Hawaiian/Part-Hawaiian, 1975



Hawaiian culture makes large families, high fertility, and the attendant variables explainable" . . . the benefits of not having children may really be costs in this cultural context." (p. 19).

In the context of needs assessment, however, the data lend themselves to a different interpretation. There is clearly a complex set of factors operating which make Waianae a community of need. Unfortunately, there is really nothing new in this analysis. There have been countless social action, health service, and educational programs in Waianae since the rough indicators of need became known. Perhaps, if anything, this new study simply points out how little has really changed over this amount of time.

On the positive side, however, the new approach also points out that a community like Kailua, generally considered a middle-class, successful residential area, is, in terms of percentages, perhaps **more representative** of the total Hawaiian population.

Perhaps what this means is that communities, like individuals, have habit patterns acquired over many years which are quite resistant to change. Perhaps what is needed is a change of image: Waianae is not a community in need because it is a Hawaiian place. It is simply a place where a large and identifiable number of Hawaiian families are subject to very severe social system pressures—along with other families who live there. Some handle this stress very well—some do not. What is needed may be a systematic program of community stress reduction. Kailua, on the other hand, may be looked at as a more modal case: again, some families making it, some not, but an overall community pattern of **fostering** upward mobility and effective participation in contemporary society.

SUMMARY AND CONCLUSIONS

It was noted at the outset that, while this report is an attempt to integrate data relevant to the needs of infants, 0-3 years old, there is little information about actual development in this age range available. There are no "standardized test scores" which might indicate relative progress. There are, however, some identified "risk factors" which do relate to the probability of successful development.

Highlights of Findings:

1. There are about 5,000 Hawaiian babies born each year (average 4,750, 1974-1978). These are about one-third of all babies born in the State, the highest percentage of any group.
2. The overall percentage of Hawaiians in the State population is not increasing, however, due to the off-setting effects of in-migration.
3. Most Hawaiian babies (about 70%) are born on Oahu, where they constitute about 25% of all births. Fewer Hawaiian babies are born on the Neighbor Islands, but they are a larger percentage of the population there.
4. Over two-thirds (average 68.3%, 1974-1978) of the Hawaiian babies born have one parent who is not Hawaiian.
5. More young (11-19 year old) Hawaiian women give birth than any other group.
6. More of these births are "illegitimate" than would be expected by population percentages. There were an average of 439 such births each year 1974-1978.

7. More Hawaiian mothers receive no prenatal care or late prenatal care than would be expected.
8. More Hawaiian babies (average 377, 1974-1978) are born with a low birthweight (less than 2,500 grams) than would be expected. The degree of disproportion is greater for "illegitimate" births (average 111, 1974-1978).
9. Findings are less clear for congenital malformations and infant death. While rates were not found to be disproportionately high over the five years of study data, the average was slightly elevated.
10. Confirmed cases of child abuse and neglect are disproportionately high for Hawaiian children. They were the largest number of cases of abuse for all but one year of study data. There were an average of 148 confirmed cases of abuse of Hawaiian children each year, 1975-1979.
11. There is evidence that while certain communities have long-standing social stress patterns associated with risk factors for infancy (Waianae), others with not insignificant numbers of Hawaiian residents (Kailua) are experiencing social successes.

Need Areas

In order to convert the large-scale data contained in this report into some estimates of need which would be useful for preliminary educational planning, a rough derivation was carried out based on the concept of a "most-in-need" group in each of four Need Areas (Table 34). These Need Areas line up with the four "risk factors" discussed in the body of the report.

Derivations of the estimates of "most in need" for Table 34 were made as follows:

I. The general target audience is high school and intermediate school students. Department of Education figures for 1977, projected over several years, indicate totals of approximately 80,000 students in high and intermediate. Hawaiian students comprise approximately 16,000 to 17,000 of this total. Data from a recent study of Windward district students (Yates, 1980) indicates that approximately 30% of high school students and 10% of intermediate school students are currently sexually active. This would mean about 17,000 - 18,000 total students and about 3,000 - 4,000 Hawaiian students. The same study indicates that only 3% actually want to have a baby, but 65% use no form of birth control. This provides us a very rough estimate of about 10,000 - 11,000 total students and about 2,000 - 2,500 Hawaiian students (boys and girls) per year who are at risk of having an unintended pregnancy.

TABLE 34

Need Areas, Goals, and "Most in Need" Groups

Need Area	Goals	Primary Target Audience "Most In Need"	Estimated Numbers, Hawaiian, By Year
I. Pre-Parenting	I. Reduce unintended adolescent pregnancies.	Sexually active high school and intermediate school students who do not want a child but are not using birth control.	2,000 - 2,500
II. Prenatal	II. Decrease risk associated with inadequate prenatal care.	Unmarried, already pregnant high school and intermediate school students.	200
III. Perinatal	III. Reduce family stress associated with risks factors at birth.	Infants identified at birth as "high risk" due to prematurity (by gestation period and birthweight) or other factors and their parents, especially high school and intermediate school students.	100 - 150
IV. Infancy	IV.A. Prevent abuse and neglect. B. Optimize infant development of adaptive skills/behavior.	Low-income, low SES multi-problem families.	4,000 - 5,000

II. The most general target audience here is already pregnant women. There are currently about 16,000 births a year, 3,500 - 4,000 of these to Hawaiian mothers. We know that 2,000 - 2,500 births a year are to mothers aged 11 - 19, and that 800 - 900 of these are to Hawaiian mothers (Table 24). There are about 500 illegitimate births to mothers 11-19 (Table 26), and recent figures from the Department of Health indicate that about 41% of these are to mothers 17 years old or below. This gives us the very rough estimate of 200 illegitimate births to high and intermediate school students per year.

III. These figures come directly from Table 33, which is based on Department of Health data showing an average of 111 illegitimate, low birthweight Hawaiian babies born during the five years of study data, out of an average of 223 total illegitimate low birthweight babies.

IV. There were an average of 4,750 Hawaiian babies born during the five years of study data. This gives an estimate of roughly 14,000 - 15,000 babies currently 0 - 3 years old. The Alu Like Needs Assessment Survey (1976) indicates that 34.1% of Hawaiian families of under 5-year old children are "welfare eligible" by federal (AFDC) guidelines. This gives the very rough estimate of 4,000 - 5,000 families of 0-3 year olds who are likely to have social, economic, or related needs which would affect their baby.

1982 UPDATE

While the above analyses, completed in 1980, focus on defining the extent of specific problems among Hawaiians, it is also of interest to consider such conditions in light of state and national trends.

Table 35 presents the number and percent of births to women under age 18 as determined for a national sample of 31 states and the State of Hawaii. In general, it can be seen that Hawaiians lead all others on this indicator within a state whose overall standing is well below that of the national average shown. In fact, on this particular indicator Hawaiians fall about midway between the national figures for Whites and Non-Whites.

Table 36 offers the same type of tabulation for number and percent of babies of low birth weight. In this area it can be seen that the state as a whole falls slightly above the national average presented, with all groups including Hawaiians falling below the average for Non-Whites nationally. An examination of the within state differences across ethnic group should take into consideration the role of

TABLE 35

Number and Percent of Births to Mothers Under Age 18: National Totals 1979, and State of Hawaii by Ethnic Group Averages, 1975-1979

	Total Number of Births	Number of Births to Mothers Under 18	Percent of Total
NATIONAL TOTAL[1]	2,099,503	125,254	6.0%
Whites	1,631,206	73,917	4.5%
Non-Whites	464,035	51,214	11.0%
Not Reported	4,262	123	2.9%
STATE OF HAWAII[2]	16,536.2	644.2	3.9%
Hawaiian	3,532.2	277.4	7.9%
Samoan	434.8	18.8	4.3%
Filipino	2,866.4	117.0	4.1%
Caucasian	5,266.8	131.4	2.3%
Japanese	2,386.2	43.4	1.8%
Korean	301.8	4.0	1.3%
Chinese	611.4	6.2	1.0%

[1] Totals from 1979 for 31 of 50 States, c.f., March of Dimes Birth Defects Foundation, 1981.

[2] Gannaway et al, 1981, 1975-1979 averages, c.f., Table 6, p. 9.

physical stature: e.g., Japanese and Filipinos as contrasted with Samoans and Caucasians.

Both of the above analyses point up the fact that Hawaiians, who often end up as the "in-need" group within the State of Hawaii, may actually be functioning at a very respectable level with regard to various risk indicators. Specifically, they may often be at about the same level as national Caucasian samples, and well below—that is "better than"—major minority groups such as Blacks and Hispanics. This general trend is one that was repeatedly encountered throughout the needs assessment study (e.g., with respect to High School Graduation rates, see Socio-Economic Status, Condition 5), leading to the specification of "stiff competition" as a culturally-related need condition (see Culturally Related Academic Needs, Barriers in the Dominant Culture, Condition 3).

Social Science Analysis

Lest the conclusion be reached that "all is OK" a study conducted by Schmidt, Onzuka, and Drorbaugh (1979) indicated that specific high-risk groups of Hawaiian mothers do exhibit levels of need that are well above State averages as well as above averages for the Hawaiian group. Table 37, for example, provides an analysis of number and percent of low birth weight babies among Hilo area Hawaiians in three specific "high-risk" groups. Although Maternal and Infant Care Clinic (MIC) clients in these groups did exhibit more favorable birth weight outcomes as a group than non-MIC care Hawaiians, it can be seen that all groups had levels of low birth weight births that approximated or exceeded those of Non-Whites nationally.

A final maternal and child health indicator comes from an investigation of short pregnancy intervals. Burch (1977) conducted a study of examining the incidence and consequences of relatively close spacing of children among Hawaii's ethnic groups. In general, he confirmed that short intervals between births of successive children (i.e., less than 27 weeks between the birth of one child and the conception of the next) does tend to increase the chances of neonatal mortality during the first month of life for the child born after a short pregnancy interval. For Hawaii's ethnic groups Filipinos and Hawaiians showed the greatest incidence of births after short pregnancy intervals (12.9 percent of single births to mothers with at least one prior birth). These were followed by "Others" (11.8%), Caucasians (6.5%), and Japanese (4.6%). Within the Hawaiian group,

TABLE 36

Number and Percent of Low Birth Weight Babies: National Totals, 1979 and State of Hawaii by Ethnic Group Averages, 1975-1979

	Total Number of Births	Number Weighing Less Than 2500 Grams	Percent of Total
NATIONAL TOTAL[1]	2,099,503	148,078	7.1%
Whites	1,631,206	96,440	5.9%
Non-Whites	464,035	51,389	11.1%
Not Reported	4,262	249	5.8%
STATE OF HAWAII[2]	16,536.2	1,239	7.5%
Filipino	2,866.4	278	9.7%
Hawaiian	3,532.2	285	8.1%
Japanese	2,386.2	189	7.9%
Korean	301.8	20	6.6%
Chinese	611.4	37	6.1%
Caucasian	5,266.8	316	6.0%
Samoan	434.8	77	3.9%

[1] Totals from 1979 for 31 of 50 States, c.f., March of Dimes Birth Defects Foundation, 1981.

[2] Gannaway et al, 1981, estimates presented here are based on an assumption that 50 percent of multiple births produce babies weighing less than 2500 grams c.f., Table 6, p. 9.

TABLE 37

Number of Births and Percent Born Weighing Less Than 2500 Grams: USA, State of Hawaii, and Hilo MIC Catchment Area

	Total Number of Births	Percent Weighing 2500 Grams
GROUP		
A. BENCHMARK FIGURES		
USA, 1979[1]	2,099,503	7.1%
USA Whites, 1979	1,631,206	5.9%
USA Non-Whites, 1979	464,035	11.1%
State of Hawaii, 1975-1979[2]	16,536.2	7.5%
Hawaiians Statewide, 1975-1979	3,532.2	8.1%
B. HIGH-RISK HAWAIIANS IN HILO MIC CATCHMENT AREA, 1968-1975[3]		
1. Mothers < 20 years old		
MIC CARE	145	11.9%
No MIC CARE	235	16.9%
2. Mothers < 12 years education		
MIC CARE	160	11.9%
No MIC CARE	287	12.2%
3. Unwed Mothers		
MIC Care	115	10.5%
No MIC Care	171	14.0%

[1] Totals from 1979 for 31 States, c.f., March of Dimes Birth Defects Foundation, 1981.

[2] Gannaway et al., 1981

[3] Schmidt, Onzuka, and Drorbaugh, 1979, Table 7, p. 10.

meanwhile, the occurrence of short pregnancy intervals was negatively correlated with age. For example, those under 25 years of age had a rate of 18.7 percent. This dropped to 9.0 percent for those aged 25-29, 6.1 percent for those 30-34, and 3.7 percent for those 35 and older. The highest mortality rates for those who delivered after a short pregnancy interval was among the Japanese (35.7/1000 births), with "Others" (22.1/1000), Filipinos (17.5/1000), Hawaiians (13.5/1000), and Caucasians (8.5/1000) following in descending order.

Major Need Category: Special Educational Needs

General Need Area: Physical Health

Condition 3: Nutrition

Condition Summary

Testimony suggests a need for improved knowledge of nutrition and for dietary changes.

Potential Educational Interventions

- Nutrition education programs.
- Home-school educational/lifestyle interventions.

Testimony

From the dominant culture prespective Marion L. Hanlon, M. D. has testified about the need for health education among Hawaiian youth (Bill 916, p. 138, See Condition 5: Health Education in the Schools). A key area in need of intervention in her view stems from a prevailing incidence of "improper nutrition" among Hawaiian school-age youth. Although she was only one voice, and she did admit that her remarks applied primarily to her island of experience, Maui, a within culture point view, that of Kekuni Blaisdell, M. D., largely affirms Hanlon's conclusion. The following excerpt from Dr. Blaisdell's column for *Ka Wai Ola O OHA* suggests how he views inadequate or less-than-optimal nutrition as part of a general health problem among Hawaiians:

> Why are we *po'e Hawaii* comparatively less healthy than our fellow non-Hawaiians in our native land?
>
> The reasons fall into three main categories: (1) the genes we have inherited from our *kupuna*; (2) our individual lifestyles with respect to what we choose to eat, our consumption of cigarettes, alcohol and drugs, our personal hygiene and our mental coping with stress; and (3) our environment, such as crowding, public sanitation, automobiling, noise, exposure to harmful chemicals, and catastrophies that may be beyond our individual control, but may be amenable to group action . . .
>
> While our ancestral genes may render us more susceptible to some illnesses, certainly we cannot, and should not, blame them for our self-abuses. Like our fellow island residents, too many of us consume "junk foods," *puhi paka, inu loa,* misuse drugs, hold distressing tensions, lack physical fitness and adequate sleep, and we thoughtlessly disrupt our delicate island ecosystems.
>
> These unwholesome behavioral traits were not characteristic of our noble *kupuna*. They are not traditionally Hawaiian, indeed, they are un-Hawaiian and even anti-Hawaiian.
>
> In Hawaii of old, care of the body, the mind and the spirit were necessary to preserve each individual's *mana*. This also entailed harmonious relationships with others and respect for one's ancestors and for nature—the land, the sea, the water, the air wind—for were they not all manifestations of the gods? How tragically far we have strayed from these precious cultural values of our *kupuna* which promoted their wellness. *(Ka Wai Ola O OHA,* Summer 1982, p. 8)

Social Science Analysis

Nutritional analyses of the diets of Hawaiian youth have been criticized by some local nutrition experts associated with the State of Hawaii Department of Health. One such study was that of K. Howard (1968). Conducted in Nanakuli as part of the ethnographic research under the auspices of Bishop Museum, it offered the following conclusion:

> The goal of this study has been to evaluate the adequacy of diet among school children in Nanakuli. The results lend support to those who have subjectively described the diet of the children in the area as inadequate. Indeed, the current study presents evidence that the proportion of children in the study sample who may be seriously undernourished is significantly higher than children from the same socioeconomic stratum on the mainland.
>
> Although the income level of most of the Nanakuli families is relatively low, this alone would not seem to account for the inadequacies reflected in the children's diet. A well-balanced diet is probably within the reach of most families, provided they select their foods judiciously. However, observations over the past two years in the community suggest that much less thought is given to a balanced diet than to quantity and ease of preparation, and that the high proportion of meals missed indicates that irregular eating habits contribute to the problem. Also, local food tastes practically exclude a reasonable consumption of fresh fruits and vegetables.
>
> A good deal of evidence has been accumulating which suggests that prolonged marginal deficiencies, such as those which appear to characterize the diet of Nanakuli school children, contribute to the perpetuation of poverty both by increasing susceptibility to illness and by directly affecting performance capabilities. It would appear, therefore, that any remedial program instituted in Nanakuli, or similar areas, which does not provide for an improved diet, will be severely handicapped in its attempt to break the poverty cycle. (pp. 105-106)

This study represents one position regarding the nutritional status of Hawaiian school age youth. An adequate representation of the opposing point of view will require further literature review work.

Major Need Category: Special Educational Needs

General Need Area: Physical Health

Condition 4: Health Care System

Condition Summary

Health care is often inadequate due to limited availability of service, cultural incompatility of services, limited family income, lack of basic knowledge, etc.

Potential Educational Interventions

- In-school support services designed to supplement out-of-school health care.
- Interagency collaboration vis-a-vis problems related to health care services.

Testimony

In developing action plans to address specific problems facing Hawaiians today, active Hawaiians convened the Puwalu Conference in 1978. In order to inform the community about the identified priority areas, the proceedings of the Puwalu conference were published. The following problem and proposal statements that were issued suggest that Hawaiians tend to view many of their health problems as unique and that cultural dimensions may be very significant factors affecting health service delivery.

> Problem: The Hawaiian Community faces a wide variety of unique health problems: accessibility of existing services, manner in which services are provided, lack of information on the part of Native Hawaiians and on the part of agencies and departments.
>
> Proposal: That a system of "Hawaiian Health Advocates" be established which would serve three basic functions:
>
> 1. Act as intermediary between the Native Hawaiian Communit, and health service providers;
> 2. Promote preventative health care;
> 3. Act as advocates for Native Hawaiian health concerns before health service providers, government agencies and other groups.

Social Indicator Data

In general, the health care system available to Hawaiians has long been hardpressed to deal with the diseases and conditions Hawaiians have faced. Widely recognized evidence of this is the rapid and steady decline in the population of pure Hawaiians since the arrival of Captain Cook in 1778. Livesay (1932), for example, laid out the following numbers in the introduction to his educational study:

> It is estimated that the population of the islands was 300,000 at the time of Captain Cook's arrival (1778). In 1823 the number of natives was estimated by the missionaries to be 142,000. The census of 1832 gave 130,000, and by 1853 the total had dropped to 70,000. In 1866, the native population was given as 57,000 and by the census of 1872 it had dropped to less than 50,000. A still further decrease, to 41,000, was recorded by the census of 1890. Beginning in 1900, United States census figures have been available, and, as shown in Table IV, these are as follows: 1900, 29,799; 1910, 26,141; 1920, 23,723; 1930, 22,636. The pure Hawaiian group is thus only 6.1 percent of the present Territorial population. (p. 20)

Among some of the early factors cited were the hardships of engaging in the intensive trade in sandalwood during the early 19th century and the susceptibility of Hawaiians to white men's diseases for which Hawaiians had no immunity (c.f., Livesay, 1932, p. 19). Another point that has been raised is that the Hawaiian medical arts had largely been abandoned due to a lack of disease:

> In very ancient times many people observed the rules of the art of healing *('oihana kahuna lapa'au)*, but in later times most of them abandoned medical practices because there was not much sickness within the race. Foreigners *(malihini)* had not yet come from other lands; there were no fatal diseases *(luku)*, no epidemics *(ahulau)*, no contagious diseases *(ma'i lele)*, no diseases that eat away the body *(ma'i'a'ai)*, no venereal diseases *(ma'i pala a me ke kaokao)*. Therefore, the *kahuna pa'ao'ao* and the *kahuna'ana'ana* were always victorious. *Ho'opi'opi'o* sorcery was a later practice, more than a century later. In the time of Kamehameha I the practices of the *Lonopuha kahunas* were revived. *Kua'ua'u* was a *kahuna* of the order of *Lonopuha*, and he taught this art of healing to the chiefs. That was the beginning of the spread of this medical art, one which was famous in the time of Kamehameha I. (Kamakau, 1964, p. 109)

Whether traditional medical arts would have helped stem the rapid depopulation remains an open question; however, at the same time it is clear that Hawaiians only gradually assimilated Western medical and health practices. For instance, Adams (1937) gave the following opinions regarding Hawaiian death rates over the years up through the 1930's:

> Some of the facts relating to physical traits are known. For example, the death rates of the Hawaiians are exceptionally high, age considered, and those of part-Hawaiians are lower, but above those of whites or Chinese. Probably their intermediate position in respect to death rates is in part a matter of biological heredity. The isolation of the Islands had protected the Hawaiians from several infectious diseases to which they are now exposed. They have not been subjected to the long selective action of such diseases and presumably they are not so well immunized as the peoples who have come. . .the bad conditions under which they live are important. They no longer have the dietetic habits of the olden time and they use the foods made available by modern commerce unwisely. The old Hawaiian theory as to the causes of disease survives, more or less, even to the present day and, because of it, the Hawaiians and, to some extent, the part-Hawaiians, tend to expose themselves needlessly to diseases that are highly fatal to them. For example, the families of lepers often try to conceal the presence of the disease and to keep the afflicted one at home. The physicians and nurses who serve in connection with public health agencies find it hard to persuade tubercular patients to go to the hospital in the early stages of the disease while there is a good prospect for recovery. Hawaiian mothers give their babies very inferior care and in some cases they seem to be afraid to co-operate with the public health agencies. Evidently the high death rates of Hawaiians and the intermediate rates of the part-Hawaiians are in large measure the consequence of bad living conditions and incompetency in the care of infants and the sick. (pp. 247-248)

In spite of the ethnocentric overtones in this passage, the general health statistics on Hawaiians over the years do lend some support to the hypothesis that health care may be an area in which assimilation has been difficult. A relatively recent study of Hawaiians and health care practice was conducted by Heighton (1968) as part of the Community Research Project in Nanakuli.

In brief, Heighton based his conclusions on the results of a survey of 539 Hawaiians in the summer of 1967 and an intensive schedule of interviews with 76 Hawaiians during 1968. Among the outcomes from his work he noted a general reluctance to use Western medical and dental services, a trend more common among men than women. For example, he found that about three-fourths of those involved in his studies did not seem to have preventive health concepts, the majority preferring to wait until medical or dental conditions become serious before they sought medical assistance. He further noted that about 86 percent of the individuals did have medical insurance, but that average family expenditures on health were markedly below mainland averages, regardless of the level of family income. His examination of stress symptoms showed about the same level of stress as a New York sample; however, low-income families living in crowded, run-down housing and women aged 26-36 were identified as two key high-stress groups. Reasons suggested for the general reluctance to use Western medical services included: (1) the concept of disease common in the area, (2) preference among community members to handle disease within a circle of family and friends, and (3) tendency among community members to avoid "confrontation" (seeing a doctor or a dentist being an undesireable "confrontation" situation). Further elaboration on this last hypothesis was offered in his conclusion:

> A major factor which results in Hawaiian people not taking advantage of modern Western medicine is the desire to avoid confrontation. The informants expressed very clearly their views on what they want from physicians, dentists, and nurses. It is difficult for medical personnel who must deal with a great many patients to be personal and warm in their approach to each one, but these people need the relationship between physician and patient to be a personal one. Medical people need to be aware of the cultural

heritage of their Hawaiian patients, which differs in significant ways from that of mainland, middle-class people. Medical specialists need to become sensitive and willing to operate in a bi-cultural situation. They must be willing to listen to a parent say that his infant has *'opu huli* (turned stomach) and then treat it as he sees fit medically and try to explain to the parent how he (the physician) sees the problem. If a patient (or a parent) feels that the physician does not know what he is talking about, the relationship will be broken and the patient will not return. A physician is expected to determine the trouble by himself. The patient feels he should answer in the affirmative any questions put to him. As far as the patient is concerned, he is ill and the burden lies upon the physician to do the healing. It is important not to belittle a patient's belief in old medical practices. Rather, if possible, it is well to praise what is good about the traditional ways, while attempting to show how modern health practices are an improvement. Never must the relationship between patient and physician lead to dispute and confrontation, or the patient may disregard the physician's advice and fail to return. All this building of relationships and individual attention, of course, takes much time and effort and points up the need for a full-fledged medical center and more professionals in the area. Such tactics would probably bear fruit in the form of greatly improved health for the people of Nanakuli. (Heighton, 1968, p. 127)

Regarding educational intervention specifically, Heighton offered the following suggestions:

> Knowledge of health is dependent upon education which is culturally relevant and fits the environment. This education should focus on the children because the adults seem fairly set in their ways.
>
> It should cover the care of eyes, ears, nose, teeth and skin problems. Children need to be helped to examine what they have learned about the community folk-medicine practices and distinguish the beneficial ones from the neutral and the harmful ones; this would be greatly facilitated if teachers learned about Hawaiian cultural practices and beliefs related to health and illness. Encouraging children to follow through on what they learn in school should be stressed. (Heighton, 1968, pp. 126-127)

On the issue of traditional Hawaiian therapeutic practices Heighton (1971) offered a more detailed analysis of test data gathered in Nanakuli. In his earlier report he had noted that three-fourths of the families reported that they knew a family member who had knowledge of traditional Hawaiian medicinal practices, and one-third claimed they knew a person outside their family who specialized in traditional medical practice. In examining the knowledge of Hawaiians regarding Western and Hawaiian health intervention practices he found that those whose knowledge was limited to Western practices did not often make use of the supernatural as part of health/medical treatment. Those who had knowledge of Hawaiian practices, meanwhile, even if they also were well-versed in Western practices, tended to make use of the supernatural more than the Western-oriented individuals. The highest use of the supernatural, though, was in the group who had little knowledge of either Western or Hawaiian health practices.

Finally, an example of work offered from the health practitioner's viewpoint is a report from Kumabe (1971). The point of this article was to note the difficulties involved in gaining the cooperation of low-income Hawaiians in the use of family planning services and in maintaining a program of contraceptive use.

Major Need Category: Special Educational Needs

General Need Area: Physical Health

Condition 5: Health Education in the Schools

Condition Summary

> Testimony suggests that existing health education efforts can be improved.

Potential Educational Interventions

- Health education that effectively addresses student needs.
- Culturally relevant health education.

Testimony

In spite of the frequency with which those who have commented on needs among

Hawaiian people point to health as a key area requiring special programs, little mention was found of a need for educational programs in the schools. One exception to this trend was the testimony of Marion L. Hanlon, M.D., past president of the Hawaii Medical Association and a specialist in adolescent health. She testified as follows:

> . . . we feel that chronic health problems still are quite prevalent among the Native Hawaiian young people and adversely affect the educational process. These are varied and, at least, on Maui, include improper nutrition. We feel that not only must we continue to identify the health defects and even intensify this identification process, but there also needs to be an educational process to teach the Native Hawaiian young people how to properly use medical care available, and also the basic health needs.
>
> This has been a failure in the educational system so far. I believe traditional health educational programs have failed. If this act is to be fully successful, a new practicable and acceptable health education program must be developed that will be attractive to the Native Hawaiians as well as all the young people of our State. (Bill 916, p. 138)

Social Science Analysis

One of The Kamehameha Schools/Bernice Pauahi Bishop Estate's commitments in the area of early childhood education has been the Kupulani Project. Initiated in 1977 after several years of careful study and consideration, this comprehensive preschool intervention program was originally designed to provide families with educational/family support services from the prenatal period through school entry at age five (c.f., Rauch & Hammond, 1977). In providing childbirth preparation for limited number of rural Hawaiian families, the project developed a Prenatal Knowledge Scale designed to test the knowledge level of women who participated in the program. As a means of getting some indication of how the performance of project participants might compare with a wider cross-section of the Hawaiian population, this test was also administered to Kamehameha Schools students who had completed a unit on birth and pregnancy in an "Exploring Childhood" course.

The results of the above research were reported by The Kamehameha Schools/Bernice Pauahi Bishop Estate's Office of Program Evaluation and Planning (1981, No. 81-82:10). While the mean number correct for the *Kupulani* participants (45.3) was slightly higher than that of The Kamehameha Schools students (42.8), the difference was not statistically significant. A further analysis of test performance according to mastery levels established by Kupulani's health professionals is shown in Table 38. It can be seen that only three out of 77 individuals who were tested (3.9 percent) scored at the desired mastery level suggested by the Kupulani health professionals, while about 60 percent scored at a satisfactory level. Clearly, there was a considerable gap between what the health professionals saw as ideal and the performance of a group of rural Hawaiian women enrolled in a specialized childbirth preparation program and a group of competitively selected Hawaiian high school-age youth who have had minimal exposure to topics related to

TABLE 38

Distribution of Kamehameha School Students and Kupulani Mothers Across Three Performance Criterion Levels Established For Kupulani's Prenatal Knowledge Scale

Kupulani Project's Criterion Levels	Kamehameha Schools Students N = 61		Kupulani Mothers N = 16	
	Number	Percent	Number	Percent
1. Desired Mastery (90% or more correct)	1	2%	2	12%
2. Satisfactory Mastery (75% - 90% Correct)	35	57%	10	63%
3. Unsatisfactory Mastery (< 75% correct)	25	41%	4	25%

pregnancy and childbirth. Perhaps these results indicate that optimal health education of a type intended to prepare families for childbirth is difficult to accomplish both in a rural setting with "high-risk" families as well as in a high school setting in which the curriculum presently provides but a brief overview.

Major Need Category: Special Educational Needs
General Need Area: Mental Health
Condition 1: Family Stress

Condition Summary

Testimony, Social Indicator Data, and Social Science Research suggest a breakup of many traditional family practices as well as the existence of conditions that tend to be stressful in today's world. A prime indicator of family stress is a disproportionately high incidence of child abuse and neglect.

Potential Educational Interventions

- Support services (e.g. counseling) for students from families in trouble.
- Preventive family life education, designed to prepare today's students for future roles as parents and homemakers.
- Special home-school programs for families in trouble.
- Interagency collaboration in addressing the needs of "multiple problem" families.

Testimony

While Americans in general have shown increasing alarm at breakdowns in family functioning and togetherness, Hawaiians, too, have been concerned with changes in their traditional family systems. For example, the Alu Like organization, a community based non-profit advocate for Hawaiian social and economic self-sufficiency, has noted the overwhelming impact of the breakdown of the *'Ohana,'* the extended family system, on Hawaiians (e.g., in *E Alu Like Mai Kakou E Na'oiwi O Hawaii*). Others, meanwhile, have focused on the negative impact of disrupted family functioning on educational outcomes. The Liliuokalani Trust (LT), for instance, has been particularly concerned with family life and its implications for adjustment in today's world, as the following comments from LT representatives indicate:

> Every day my staff face the frustrations of assisting children and families to cope with the complexities of modern day society without the basics that only a relevant education can provide. One that provides not only the necessary academics, but also instills a sense of pride and dignity in one's cultural heritage.
>
> Because we are a child welfare agency, we see the impact of multiple losses faced by the Hawaiian people, the social breakdown of the children and families. I cannot stress enough that this breakdown is correlated with the educational needs of our children and adults which can only be met adequately through special assistance.
>
> Our agency has had to develop special programs to meet this need of our children. Often the staff feel disheartened because they know that with our limited funds, we can assist only the tip of the iceberg (Malia Craver, Bill 916, p. 107).

Question: How many years do you think it will be before your department can report the statistics on Hawaiians are pretty much averaged out, or at least no worse than other races?

Answer: I really don't know. By counseling we hope to assist families to become more independent and to make them feel good about themselves. That's what the Liliuokalani Trust is doing right now. They're using some of the old cultural practices to solve family problems by working within the total family, or by bringing in a respected outsider if hostilities are too strong.

It's through the group process of using the family strength, and family know-how to zero in on its own problems. This contrasts with having counselors sit down with the parents, then the kids and then the school people, and so forth.

The family method is a very old method and it works. Liliuokalani Trust tests show that families that use it solve problems a lot faster. Now they are going to try to use the same method with non-Hawaiian families and have a comparison. If this pans out as we hope, then I can say that within five years we can see some possible drop in welfare loads generally, and in the Hawaiian load (Interview with Myron Thompson, *Honolulu Star Bulletin* August 24, 1972).

Among educators, meanwhile, a range of concerns related to family life such as family dynamics, child abuse, and lifestyle changes have been raised:

> . . . there was a day I remember when I, rather than teaching remedial skills, went into just a rap session. Many of them need this because they are not able to talk it out with their parents, and not being able to have counseling services available to them. I feel, because I'm a mother of six children, and a homemaker, that I can communicate with them (Donna Kapu, Bill 916, p. 144).
>
> There is a lot of unreported child abuse (Henning, 1978a).
>
> Today, we find Hawaiians at a crossroads in struggling to exist as a people. They have lived through various stages of Rule, that of the Ruling Chiefs', Europeans and now the United States of America.
>
> The influence of the Western culture, laws, impacted the Hawaiian lifestyle and practices of the family. In turn, this caused the degeneration of family . . . (Kamahana, NHSC Testimony, 1982).

Social Indicator Data

The 0 - 3 needs assessment conducted by the Office of Program Evaluation and Planning (1980, Report No. 80-81: 26) included an analysis of the extent of child abuse and neglect among Hawaiians as a key indicator of family stress.

Table 39 offers a tabulation of abuse and neglect statistics from 1975 through 1979 for seven different ethnic groups in the State of Hawaii. In general, it can be seen that Hawaiians accounted for nearly one-third of confirmed abuse and neglect cases during the years 1975-1977. More recently, however, this percentage has dropped closer to one-fourth as the incidence of confirmed abuse and neglect cases among racial mixtures other than part-Hawaiian has climbed dramatically. (N.b., authorities insist that there were no definition changes; however, solicitation of ethnicity information does depend upon the interviews of social workers sent to confirm reported cases of abuse and neglect.)

Figure 30 shows graphically how Hawaiians compare to other ethnic groups in the state in terms of the absolute numbers of confirmed child abuse and neglect cases. The marked increase in cases for persons of "mixed" ethnic background (all mixtures excluding part-Hawaiian) is a phenomenon that is still not understood in terms of the underlying factors associated with the steep climb shown. Moreover, it is not known if the decline for Hawaiians represents a downward trend or a dip in a generally rising series.

Social Science Analysis

Several recent reports regarding child abuse and neglect in the State of Hawaii have exam-

TABLE 39

Confirmed Child Abuse and Neglect by Ethnicity of Victim, 1975-1979

Ethnicity of	1975				1976				1977				1978				1979			
Victims	Abuse	%	Neglect	%	Abuse	%	Neglect	%	Abuse	%	Neglect	%	Abuse	%	Neglect	%	Abuse	%	Neglect	%
Hawaiian	70	26.7	47	29.2	142	36.3	68	28.0	171	31.0	95	32.8	199	27.0	84	22.6	160	22.4	69	17.4
Caucasian	66	25.2	60	37.3	78	19.9	80	32.9	137	24.9	94	32.4	168	22.8	104	28.0	150	21.0	131	33.1
Mixed	44	16.8	19	11.8	38	9.7	13	5.3	58	10.5	28	9.7	162	22.0	84	22.6	198	27.8	103	26.0
Samoan	25	9.5	3	1.9	16	4.1	9	3.7	37	6.7	7	2.4	54	7.3	12	3.2	54	7.6	5	1.3
Filipino	14	5.3	15	9.3	33	8.4	17	7.0	49	8.9	15	5.2	43	5.8	18	4.8	45	6.3	28	7.1
Japanese	2	.8	4	2.5	11	2.8	9	3.7	13	2.4	12	4.1	15	2.0	6	1.6	25	3.5	6	1.5
Other	41	15.6	13	8.1	73	18.7	47	19.3	86	15.6	39	13.4	97	13.1	64	17.2	81	11.4	54	13.6
TOTAL	262	100.0	161	100.0	391	100.0	243	100.0	551	100.0	290	100.0	738	100.0	372	100.0	713	100.0	396	100.0

ined rates of occurrence within different ethnic groups. For example, Dubanoski and Snyder (1980) contrasted abuse and neglect among Japanese in Hawaii with that among Samoans, and subsequently, Dubanoski (in press) considered civilian Caucasians and Hawaiians. Table 40 summarizes the general findings of these two reports in terms of the actual occurrence of abuse and neglect over a specific time span as contrasted with the incidence that would be expected on the basis of percentage representation in the general population.

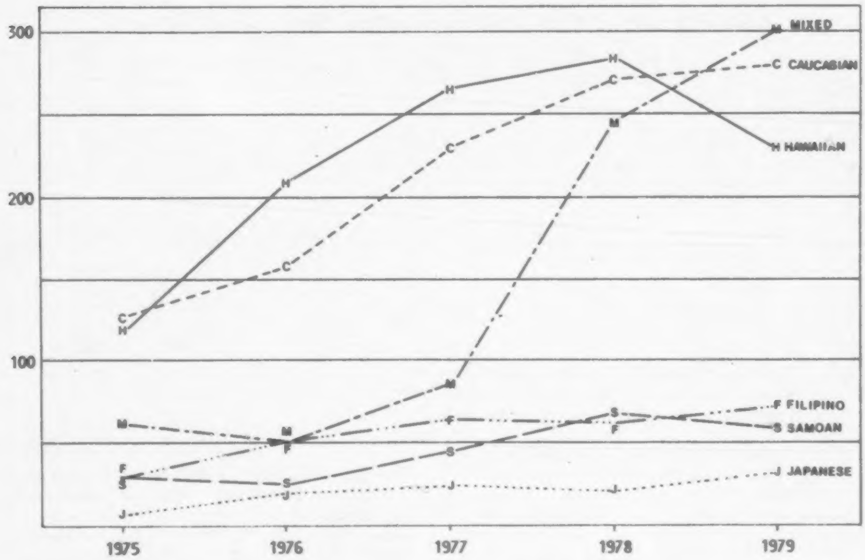
The data in Table 40 reveal that child abuse and neglect, at least as Western society defines it, occurs at an extremely high rate among Samoans living in Hawaii. The percent of expected figures shown may be inflated somewhat due to the fact that the Samoan population is difficult to estimate in terms of its size; nevertheless, it is clear that child management which is reportable and confirmable as child abuse and neglect occurs at a much higher rate per capita among Samoans than among other major ethnic groups in the state.

Hawaiians, meanwhile, show a somewhat higher level of abuse and neglect than might be expected on the basis of their representation in the general population. However, as in the case of some of the physical health areas reviewed under that general need heading, it can be seen that part of the reason Hawaiians may surface as one of the primary "in-need" groups in the area of child abuse and neglect could be due to contrast effects with other groups in the state. In this case, for example, the incidence of abuse and neglect is apparently extremely limited among Japanese as contrasted with other groups.

Dubanoski (in press) also conducted an analysis of the records kept by social workers from confirmation interviews with families who had been reported to Child Protective Services as abusers or neglecters. In most cases social workers recorded what seemed to them to be the key factors associated with the indi-

FIGURE 30

Total Number of Confirmed Abuse and Neglect Cases, 1975-1979



vidual instances of abuse or neglect. For example, Table 41 provides a tabulation of six general types of family stress that social workers found to exist in families in which abuse or neglect occurred. Thus, with Hawaiians "family discord" was considered a factor in 40 percent of the 330 abuse cases that were confirmed, while "insufficient income" was considered a factor in 37 percent of the 161 neglect cases.

Further analysis of social worker confirmation interview records is offered in Table 42. In this case it can be seen that "loss of control" and "lack of tolerance" were personal factors in almost half of the instances of confirmed abuse among Hawaiians. With neglect, meanwhile, a history of abuse was found in 13 percent of the cases. In both the analyses of stress factors as well as those of personal factors it is obvious that more than one factor was included for many families. In short, it is clear that Hawaiian families who become involved in cases of abuse or neglect that eventually get confirmed by the State of Hawaii are by-and-large "multiproblem" families.

Polynesians. Their basic point was that Polynesians do in fact tend to account for a disproportionately high percentage of instances of child abuse and neglect in the communities in which they live. In particular they provided evidence from the Maoris in New Zealand and the Hawaiians in the State of Hawaii. From their viewpoint, given a strong anthropological background, they considered modern day abuse and neglect to be due to a general breakdown in traditional childrearing patterns, a trend attributable largely to Westernization and urbanization.

Specifically, they ventured the opinion that parts of traditional Polynesian social systems still exist today (e.g., sibling caretaking, allowing young children substantial independence, etc.); however, these remnants tend to survive, in many cases (e.g., in urban settings), under conditions in which key elements of the traditional overall child rearing system are missing. The results of a partial preservation of traditional social forms and family systems, they claim, are family stress, depression, and other maladaptive outcomes such as child abuse.

TABLE 40

Incidence of Child Abuse and Neglect in Four Ethnic Groups in Hawaii

		Civilian Caucasians	Hawaiian/ Part Hawaiians	Japanese	Samoan
CONFIRMED CASES OF CHILD ABUSE	Percent of State Population	18.9%	19.4%	27%	.8%
	Total Number of Confirmed Cases in the State	1,498[a]	1,498[a]	942[b]	942[b]
	Expected on Basis of Percent of Total Population	283	291	254	8
	Actual Number of Cases	243	330	39	61
	Percent of Expected	86.0%	113.0%	15%	763.0%
CONFIRMED CASES OF CHILD NEGLECT	Total Number of Confirmed Cases in the State	762[a]	762[a]	533[c]	533[c]
	Expected on Basis of Perccent of Total Population	144	148	144	4
	Actual Number of Cases	243	161	30	19
	Percent of Expected	169.0%	109.0%	21	475.0%

[a] Dubanoski, **in press** for period January 1978 - March 1980.

[b] Dubanoski and Snyder, 1980 for period 1976 - 1977.

[c] Extrapolated; exact figure not provided in the article.

Finally, the issue of abuse as viewed from a cultural standpoint has received some comment recently. For example, Korbin (1981) addressed many of the issues with respect to cultural factors associated with abuse and neglect. As part of this effort Ritchie and Ritchie (1981) analyzed abuse among contemporary

One example used to illustrate their point is that of a child who is left to care for a younger sibling. In a traditional setting adult assistance is generally close at hand, and in most cases is very likely to be a member of the extended family. Thus, should there be an emergency, the sibling has adequate resources on which to lean. In an urban setting, however, not only is the general environment, including the housing, more dangerous for a young caregiver and his or her charge, but adult assistance from extended family members may be miles away and unavailable in an emergency. The following brief comment summarizes the Ritchies' (1981) proposed educational solution with respect to child abuse:

> To us it seems that a strong hope lies in reconstruction. We believe that the Polynesian heritage rests upon Polynesian child rearing. We believe that a conscious and deliberate conservation of that pattern would prevent child abuse. We know of intact New Zealand Maori communities, old enclaves around which wider communities have grown. Within these communities child abuse is as unthinkable as it ever was. The first step in

TABLE 41

Stress Factors Associated with Confirmed Cases of Abuse and Neglect Among Caucasians and Hawaiians, 1978-1980

Number of Confirmed Cases	Caucasians				Hawaiians			
	Abuse 243		Neglect 243		Abuse 330		Neglect 161	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Broken Family	73	30%	98	40%	82	25%	52	32%
Family Discord	72	30%	45	19%	132	40%	31	19%
New Baby/ Continuous Care	44	18%	68	30%	87	26%	54	34%
Recent Relocation/ Social Isolation	41	17%	89	37%	39	12%	28	17%
Insufficient Income	33	14%	44	18%	66	20%	59	37%
Inadequate Housing	10	4%	34	14%	25	8%	19	12%
Unclassified	104	43%	70	29%	98	30%	38	24%
TOTAL*	377		448		529		281	

*Some cases have more than one stress factor; percents do not total 100%.

Source: Dubanoski, in press, p. 22

TABLE 42

Personal Factors Associated with Confirmed Cases of Abuse and Neglect Among Caucasians and Hawaiians, 1978-1980

Number of Confirmed Cases	Caucasians				Hawaiians			
	Abuse 243		Neglect 243		Abuse 330		Neglect 161	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Abuse History	27	11%	12	5%	75	23%	21	13%
Spouse Abuse	30	12%	7	3%	65	20%	15	9%
Normal Discipline	30	12%	11	5%	62	19%	7	4%
Loss of Control	87	36%	9	4%	158	48%	13	8%
Lack of Tolerance	96	40%	15	6%	163	49%	18	11%
Mental Health Problem	52	21%	51	21%	54	16%	17	11%
Alcohol/Drug Dependence	50	21%	48	20%	51	15%	17	11%
Mental Retardation	8	3%	1	< 1%	7	2%	6	4%
Physical Handicap	0	0	13	5%	0	0	11	7%
Police/Court Record	8	3%	11	5%	21	6%	13	8%
TOTAL*	388		178		656		138	

*Some cases have more than one personal factor; percents do not total 100%.

Source: Dubanoski, in press, p. 22.

> reconstructing a viable urban equivalent is for Polynesians to recognize the salient features of their child-rearing system so that they know what to protect. Time and again, when we have told Polynesian groups our analysis of the major features of their child-rearing style, they have said yes, that is how their childhood was; they recognize the pattern, they remember how nice it was. But in all the discussion of cultural preservation we have never heard the central role of child rearing acknowledged. Instead, the emphasis is on preservation of language, community ceremonial facilities, traditions, oratory, and song and dance. All these are important, but none of them will prevent disorganization from reaching down into the heart of family relationships (pp. 200 - 201).

Major Need Category: Special Educational Needs

General Need Area: Mental Health

Condition 2: "Fear of Learning"/ Depression

Condition Summary

Years of subordinate status in their own homeland has apparently affected the personal adjustment of many Hawaiians. For example, observers note "Fear of Learning" as well as other indicators of generalized depression and withdrawal.

Potential Educational Interventions

- Support services for students who experience personal adjustment problems.

Testimony

The concept of "fear of learning" was used in discussions of the problems of Native Hawaiians in 1978 when Hawaiians first sought special educational benefits through a Native Hawaiian Education Act. For example, a newspaper account of Senator Inouye's testimony highlighted this concept:

> . . . He [Inoùye] said federal assistance is urgently needed to combat 'fear of learning' among Hawaiian young people.
>
> 'They are all too often reconciled to failure—a failure that they have grown to expect, which they believe is inevitable,' Inouye said.
>
> 'Hawaiian leaders have come to realize that if their people are to ever gain self-determination, this fear of education must first be overcome' (Lammi 1979).

Concerns about "fear of learning" were also expressed by several individuals who testified in hearings for Senate Bill 916. For example, the following came from Hawaiians as well as non-Hawaiians:

> I feel that it [Bill 916] is the most important and critical, and exciting because it has the potential of addressing the basic cause of all of the negative statistics that have been quoted in this meeting and in other reports throughout the years.
>
> It has the potential of addressing the basic cause which is a tremendous fear on the part of too many of us to learn. To learn is to be punished. To learn is to get hurt, and, therefore, we back off. This bill gives us the potential for addressing that issue (Myron Thompson, Bill 916, p. 86).
>
> The current situation described in Senate bill 916—a fear of learning among Native Hawaiians—contrasts strikingly with their accomplishments when they first came in contact with formal schooling. Their high literacy rates then were the envy of other nations. This is an indication that learning itself is highly valued among Hawaiians and that what they fear now is a kind of schooling that has become more and more isolated from Native Hawaiian communities and less and less interlinked with Native Hawaiians' broader social goals (Carol Eblen, Bill 916, p. 131).
>
> I would like to quote from Senator Inouye's letter. Just a very, very important statement that I thought would be good this morning. He says: "If Native Hawaiians as a group are ever to improve their self-esteem and economic opportunities; this fear of failure must first be overcome with the help of programs such as these." And I strongly and wholeheartedly agree with that statement (Donna Kapu, Bill 916, p. 143).

A slightly lengthier account was offered by Byron Cleeland, a Hawaiian language instructor from Kauai. He concluded that dropping out and a lack of interest in learning seems to extend even to subjects that one would expect to be of high intrinsic interest to Native Hawaiians:

> Of approximately 55 Hawaiians or part Hawaiians who enrolled in my Hawaiian language classes at the community college during the past 4 years, 32 either dropped out without finishing the class or were otherwise unable to satisfactorily complete the course.
>
> Of course, many were disillusioned when they discovered that being part Hawaiian wasn't necessarily much of an advantage when it came to learning to speak a language with which they were more unfamiliar then they realized. But a dropout rate of almost 60 percent is still too high to be ignored.
>
> Also, these figures do not include 30 members of the Kaumualii Hawaiian Civic Club who took the course as a group project in 1976. Although everyone in that class was either Hawaiian or part Hawaiian and had demonstrated an interest in Hawaiian culture by joining the organization, only half of the members stayed in the class long enough to even receive credit.
>
> In my high school Hawaiian language class, approximately half of the students are part-Hawaiian.
>
> Once again, there is a wide variety of abilities. But there are also too many examples of attitudes which Senator Inouye describes as complacency, fear of learning, and reconciliation to failure.
>
> It's understandable when students with below average ability give up when trying to keep pace with more able students, but it is disheartening to see intelligent, capable students make only minimal attempts to put in the time and effort necessary to learn a language which they are truly interested in learning. It is also disheartening to see these same students having no plans for what they will be doing after they graduate from high school (Byron Cleeland, Bill 916, pp. 196-197).

A connection between an apparent "fear of learning" and generalized feelings of inferiority, sadness and depression has been hypothesized to underlie the negative social, economic, and educational statistics of Native Hawaiians. For example, Myron Thompson, Trustee of The Kamehameha Schools/Bernice Pauahi Bishop Estate, recently offered the following analysis in interviews with reporters:

> Based on his experience as a social worker, trustee Thompson said he believes that deeply ingrained feelings of cultural inferiority are partly responsible for Hawaiian children averaging below state and national norms academically.
>
> 'Since (Capt. James) Cook landed, there have been a lot of putdowns for Hawaiians, and you still see the dregs of it today. Where does it get started? At birth. In the family' (*Honolulu Star Bulletin*, May 19, 1982).
>
> 'We Hawaiians are an enigma,' says Myron B. Thompson, . . . 'We are fascinated by our history, though much of it is nightmarish. We are a compassionate people, fiercely proud of our cultural heritage, and we are outraged to see our fragile physical setting—our tropical waters, mountains, air, flora, and fauna—being polluted and trampled to death by civilian in-migrants, whose numbers have tripled in the past decade.' As a result, too many Hawaiians 'have a low self-image,' Thompson adds. 'Too many function in a constant state of depression. This state of mental ill-health results in social failure, delinquency, unemployment, and unrealized potential' (Shaplen, 1982).

Social Science Analysis

In the social science literature the ideas regarding depression expressed by Hawaiian leaders have been discussed in [illegible]e detail by psychologists and psychiatrists concerned with a phenomenon some call "masked depression." For example, Hollon (1970) offered the following conclusion in his discussion of poor school performance:

> Depression in children has received little attention but it is more common than is generally assumed although it is often masked by other forms of behavior disturbance. A number of children initially referred for psychological testing because of poor school performance were found upon evaluation to be suffering un-

derlying depression which was the true source of their school failure (p. 263).

He also offered the following perspectives on symptomology and intervention:

> . . . features which can be best described as depressive are definitely evident in feelings of inadequacy, feelings of worthlessness, conviction of rejection by others, and guilt, along with helplessness and hopelessness which undermines all effective effort.
>
> Robert Gould (1965) reports that depression among adolescents and children is seen much more often than is generally assumed and he considers it to be much more prevalent than is evidenced from the literature. Typical characteristics of depression described by Gould include loss of interest in one's environment and loss of drive, feelings of sadness and emptiness along with feelings of loneliness, but these may be disguised under surface behavior or as temper tantrums, boredom, restlessness, rebelliousness, hypochondria, preoccupation and running away (p. 258).

He continued:

> Yet it is obvious that where depressive features are the major source of the student's underachievement, viewing his problem as merely one of indolence or daydreaming to be dealt with by educational techniques, tutoring, or exortions to greater efforts will not only be ineffective in improving school performance but will often give way to critical, disapproving and demanding attitudes on the part of adults that will increase the underlying depression. For this reason it is especially important that teachers and parents be able to recognize signs of depression as well as the fact that these can often be camouflaged by other forms of behavior disturbance (p. 259).

The above testimony and social science analysis introduces the notion of stress and depression. Chapter V of this report will discuss this in more detail.

Major Need Category: Special Educational Needs
General Need Area: Mental Health

Condition 3: Problems in Childrearing

Condition Summary

Child abuse and neglect, runaways, and Testimonial Data suggest a disproportionately high incidence of problems in childrearing.

Potential Educational Interventions

- Support services or alternative education for youth whose behavior is considered inappropriate.
- Special parent-training programs for families in conflict.
- Comprehensive early childhood education programs during infancy and/or preschool years.

Testimony

Testimony presented for the other conditions under the general need heading "Mental Health" all point to an area of mental health services that is more preventative than remediational. That is, other than the extreme problems found in certain "multiproblem families," the problems of youth whose social behavior is clearly "deviant," and the problems of youth who are unable to adjust socially/behaviorally to the requirements of a school setting, there are the problems that "average" families encounter during the course of childrearing. These are not the types of problems that evoke explicit testimony; however, they can be inferred from the body of material that outlines the "severe" problems within the general purview of mental health. In short, where there is evidence of "fire"—i.e., evidence of substantial mental health needs—it can be assumed that there is also a need for preventative work with families that may be on the verge of a major problem or in the early stages of development with respect to later problems. Thus, all testimony related to other mental health needs also applies to this condition.

Social Indicator Data

Refer to Condition 1: Family Stress for data regarding child abuse and neglect.

Social Science Analysis

Mathews and Ilon (1980) recently conducted a review of the clientele of Hale Kipa-a home for runaways in Honolulu. In presenting their analyses they outlined some of the unique conditions and restraints associated with this particular social problem in the Hawaiian context. For example, they described the geographic limitations stemming from the fact that Hawaii is an island state, the unique cultural factors at work in many Island families, the diversity of family constellations to be found in Hawaii, and so forth. Their overall conclusion, based on the statistical analyses conducted, was as follows.

> The results clearly indicated that race is a factor in running patterns. While Caucasian runaways are less likely to become chronic runaways than other racial groups in Hawaii, the opposite is true of Hawaiian or part-Hawaiian runaways. A possible explanation of this might be that children from Hawaiian families wait until the situation from which they are running becomes unbearable and perhaps beyond redemption, or, alternatively, it might indicate that the cultural attitudes within the family affect the status of and the behavior toward the potential chronic runaway. It could also mean that the vast network of extended family and friends offers an attractive refuge for the runaway making multiple runs easier. (p. 408)

While Mathews and Ilon found evidence that Hawaiians who use Hale Kipa tend to be chronic runaways, the data they reported showed Hawaiians accounting for only 17 percent of all runaways served by the facility. Given that Hawaiian school-age youth aged 6 - 18 account for about 24 percent of the population within this age range (cf. OEO Census Update Survey, 1975), this appears to be an underrepresentation with respect to their presence in the general school-age population.

In considering this apparent underrepresentation of Hawaiians as clients of the temporary shelter, it does seem—based on general cultural considerations—that Hawaiians who run away from home would most likely rely on family resources rather than on an agency such as Hale Kipa. In fact, having any Hawaiians show up at such a facility may be testimony to the breakdown in the Hawaiian *'ohana* (extended family) system that has been mentioned elsewhere. In any event, one would be inclined to hypothesize that that the runaway problem among Hawaiians would not be accurately gauged by Hale Kipa contact records. In fact, Honolulu Police Department records for juvenile arrests for 1981 (refer to Alienation, Condition I: Crime and Juvenile Delinquency) show that Hawaiians accounted for 44 percent of the arrests for runaways, the numbers of youth involved being at least twice as high as the numbers arrested for this offense among members of other ethnic groups in the state.

This information about runaways from Hawaiian families serves much the same function as all other mental health data. That is, it serves as an indicator that family problems/problems in childrearing do exist in Hawaiian families, and that there may well be a need for family life education and other preventative educational intervention aimed at families. There has been a trend in the social sciences during the past few years towards development of such programs, and comments from local researchers suggest that they see a need for them. For example, Dubanoski (in press) recently offered the following suggestions in his analysis of child abuse and neglect in Hawaiian families:

> Treatment and prevention programs for Hawaiian - Americans should include certain components important for the specific patterns and determinants of child abuse found in this culture. Skills must be developed to handle family life problems that may have led to family discord and spouse abuse [spouse abuse was found to co-exist in 20 percent of the homes where child abuse was confirmed]. Support services would also be important in which trained personnel can offer help and services to develop effective parent skills (commonly not found in individuals who were abused as children or in people who frequently use physical punishment) and to reduce the burden of continuous child care which was a problem within the Hawaiian-American group. Finally, programs such as relaxation training may be useful since loss of control and lack of tolerance contributed significantly to child maltreatment in this culture. (p. 14)

Indicators of the need for programs of the general sort described here also came from the Office of Program Evaluation and Planning's educational needs assessment on the island of

Molokai (1979, Report No. 78-79: 36). Specifically, one barrier to educational achievement that was identified was: "The generation gap (age gap) interferes with parent/child communication about school life" (p. 44). The recommended intervention in this case was: "Increase structured opportunities for parents/children to communicate about school" (p. 44). In this same general vein, Gallimore, Boggs, and Jordan (1974) reported that Hawaiian parents may not apply much pressure in regards to schoolwork, even though they do value education highly—and they seem interested in finding out how they can approach problems of absenteeism and its relationship to failing to finish high school:

> . . . while 91 percent of the adolescents had regular chore responsibilities, 67 percent had been or were employed, only half mentioned they experienced parental pressure for good school performance. Obviously, the lack of pressure—if our data are accurate—does not reflect a lack of interest or appreciation for the benefits of education. Indeed, many parents we met in Pumehana, who knew of our research in the schools, asked specifically for advice on how to encourage attendance and insure graduation. (p. 180)

Finally, the surveys conducted in connection with the recent evaluation of The Kamehameha Schools/Bernice Pauahi Bishop Estate's Extension Education Division revealed that a key area of interest among potential consumers for new program development was "Family Life Education for Teens." This seems to suggest a general perception among Hawaiians that learning about family life and childrearing in school is an important educational need area. Community leaders surveyed, on the other hand, were less enthusiastic about the potential interest in and need for such programs. However, all things considered, family life education directed at school-age adolescents was identified as a new program type with "High Market Potential" (Office of Program Evaluation and Planning, 1981, Report No. 80-81: 52).

Major Need Category: Special Educational Needs

General Need Area: Mental Health
Condition 4: Problematic Social Behavior

Condition Summary

A disproportionately high use of Mental Health Services indicates an apparently high incidence of psychological and mental health problems.

Potential Educational Interventions

- Support services for youth with mental health problems.
- Preventive mental health programs designed to reduce the future incidence of such problems.
- Special home-school programs for families in which mental health problems interfere with educational activities.
- Interagency collaboration in addressing special family needs.

Testimony

While the general trend among Hawaiians in the area of use of health services tends to be towards underutilization, testimony from Dr. Denis Mee-Lee, Chief of the Mental Health Division, State of Hawaii Department of Health, indicates that this is apparently not the case with respect to mental health services:

> We have been concerned that a good number, in fact, a larger proportion of Hawaiian people and children have been seeking mental health services on a per capita basis than other ethnic groups. I think this again speaks, along with other data that has been presented, that there are a good number of social emotional need problem areas that have not been attended to in the educational system or other aspects of our society. (Bill 916, p. 135)

Other than this testimony there was little commentary directed specifically at the area of mental health. Of course, many of the problems that might ordinarily be discussed here such as juvenile delinquency, substance abuse, truancy, school achievement problems, school adjustment problems, etc. are covered in other parts of this report.

The issue of sexual preferences did come out in a needs assessment Henning (1978c) conducted on Molokai. Specifically, she noted that, "There are about nine male and six female homosexual students at the high school all of whom are Hawaiian. Their behavior has caused some problems for them and among the student body." With Molokai High School having an enrollment of 721, 15 homosexuals whose sexual preferences have created social problems amounts to about 2 percent of the student body. Certainly this seems to be an unusually high percentage, apparently indicative of a presumably localized problem.

Social Indicator Data

A preliminary review of the knowledge base regarding Native Hawaiians and their use of mental health services suggests that this has not been a particularly popular topic for investigation. In general, the information found tended to be somewhat dated, and with little emphasis among the Hawaiian organizations on analysis of mental health social indicator data. The Alu Like Needs Assessment (1976), for example, did not include mental health statistics, and their ongoing work in needs assessment has not included anything on mental health services per se.

The most recent study reviewed came from Mebane, Kamahele, and Carpenter (1976). They did a three month analysis of admissions to the Hilo Counseling Center in the Fall of 1974. Table 43 provides selected data from their report, along with the admission rates to the State Hospital from Gudeman 1967a. It can be seen that Caucasians were overrepresented as clients at the Hilo center, while Japanese were underrepresented. Hawaiians, meanwhile, were served in proportion to their representation in the population of the area.

Overall, this appears to be an area in which further investigation is needed.

Major Need Category: Special Educational Needs
General Need Area: Mental Health
Condition 5: School Behavior Problems

TABLE 43

Admissions at Hawaii State Hospital and Hilo Counseling Center By Ethnic Group

Ethnic Group	Hawaii State Hospital[1] % of Total Admissions	Hilo Counseling Center September-November 1974 % of Big Island Population	Hilo Counseling Center September-November 1974 % of Total Admissions
Whites			39%
Portuguese	32%	20%	10%
Part Hawaiian	12%		21%
Hawaiian	3%	22%	.5%
Japanese	30%	38%	15%
Chinese	4%		1%
Filipino	13%	10%	5.9%
Others	6%		7.6%

[1] Gudeman, 1967. Source: Mebane, Kamahele & Carpenter, 1976, Figure 1, p. 46.

Among some of the older sources reviewed—e.g., Wedge & Abe, 1949; Schmitt, 1956; Kimmich, 1960; Enright & Jaeckle, 1963; Katz, Gudeman, and Sanborn, 1966; Gudeman 1967a, 1967b—there certainly did not appear to be an overrepresentation of Hawaiians in the State Hospital. However, Kimmich (1960) did note that, "The Japanese have the lowest admission rate to the hospital, while the Caucasian, Filipino, Hawaiian and Other Races categories have admission rates considerably above the All Races figure."

Condition Summary

Testimony and Social Indicator Data suggest a disproportionately high incidence of school adjustment problems.

Potential Educational Interventions

- Support services and/or alternative education for students whose behavior is considered unacceptable.
- School mental health programs, including school-home programs, designed to prevent and/or treat various behavior problems.

Testimony

The mental health needs most directly related to education are those of children whose in-school behavior has proved exceptionally problematic. In general, it appears that Hawaiian youngsters are overrepresented in the group of school-age youth whose behavior requires a formal referral for services or some other formal recognition of a problem situation. Testimonial statements regarding this set of circumstances include the following:

> Teachers who participated in a study that followed 1,000 children found that Hawaiian children ranked high in incidences of achievement and behavioral problems. Included in the latter are problems such as inability to sit still in class, uncontrolled emotions, marked inability to concentrate, extreme irritability, unusual fear and anxiety, and other behaviors reflective of a lack of self-confidence (Carol Eblen, Bill 916, p. 131).
>
> . . . the third area is just re-echoing what has been said in previous testimony in regard to the mental health needs of our young people. The cultural clashes have resulted in acting out behavior, unacceptable behavior, that has in many instances destroyed the educational opportunities of Native Hawaiian young people (Marion Hanlon, Bill 916, p. 138).
>
> Extracted data from the DOE 1976 Ethnic and Language Survey, show that Hawaiian and Part-Hawaiian middle-grade students need services. These students have high rates of suspension, expulsions, court referrals, and discontinuous special education services (Myron Thompson, Bill 857, p. 187) . . .
>
> According to the 1976-77 statistics provided by the Law Enforcement Assistance Administration office, 30 percent of those suspended from school in the Hawaii island school district are Hawaiian and Part-Hawaiian. That means on this island (George Kahumoku, Bill 857, p. 30).
>
> The reasons Hawaiian children were admitted to our preschool also reflect the pressures and stresses to which Hawaiians have been subjected for several generations. Over a third of the Hawaiian children were enrolled for social adjustment reasons. Some 18 percent of the Hawaiian children were enrolled because of emotional disturbance (Joan Bristow, Bill 857, p. 113).

Additional comments in this regard pointed up the opinion that behavior problems in school may be attributable in large part to discipline problems in the schools.

> Discipline is not consistent; there is no indication to students that anyone cares (Henning, 1978a).
>
> Fair and stable discipline is needed (Henning, 1978b).

Because this area is one in which the search process did not produce a great deal of information, this need condition may need further investigation in the future.

CHAPTER V
Culture Loss and Stress Among Native Hawaiians

"Na kanaka 'oku'u wale aku no i kau 'uhane"
"The people dismissed freely their souls and died."
— Hawaiian saying cited in Young, (1980)

Cataclysmic cultural change, the kind of change which can lead to the loss of the very will to live, has occurred in Hawaii. Earlier in this report we described the ecological model of Bronfenbrenner (1979) which includes the concept of "transforming experiment:" the "systematic alteration and restructuring of existing ecological systems in ways that challenge the forms of social organization, belief systems, and lifestyles prevailing in a particular culture or subculture" (p.41). The islands of Hawaii have been thrust into the modern world in a series of such transforming experiments. As the theory points out, changes at the macro-system level will produce changes at the individual and family levels as well. It is the meaning of this upheaval in Hawaii, its implications for the daily lives of modern Hawaiians, which concerns us here. Has massive change caused a loss of culture so severe that a chronic kind of depression exists among modern Hawaiians? Could this account for lowered academic performance and other negative outcomes for Hawaiians?

This has been a recurring theme among writers and observers of the social and cultural context of modern Hawaii. In the book *Strangers in their own land: Self-disparagement among ethnic Hawaiian youth* (1972), Donald McNassor and Randall Hongo write:

> The fear in Hawaiians of losing ethnic identity is well known. There is deep concern over the loss of language, traditions, skills. One Hawaiian school teacher expressed it sadly to us thus,"I fear the Hawaiians will soon exist as a cultural entity no more. The sentiment is so open and prevalent, it does not have to be documented by extensive research." (p.18)
>
> The Hawaiian youth in this study feel a sense of alienation. They feel alienated from the majority Japanese culture with its emphasis on higher education, artistic achievement, business entrepreneurship, and political influence. They feel alienated from the corporate Caucasian enterprises that surround them. That world simply does not have any future for them in their minds except as laborers or service personnel. The thought of one day being among upper levels of management in one of the major hotels or in agriculture is inconceivable to them. They constantly refer to themselves as people whom other groups consider to be intellectually inferior in academic performance, happy-go-lucky and uninhibited, destined to use their hands, not to develop their heads. (pp. 10-11)

It is these kinds of feelings of inferiority, sadness, and depression which have been hypothesized to underlie the negative social, economic, and educational statistics of Native Hawaiians. For example, Myron Thompson, Trustee of The Kamehameha Schools/Bernice Pauahi Bishop Estate, recently offered the following analysis in interviews with reporters:

> Based on his experience as a social worker, Trustee Thompson said he believes that deeply ingrained feelings of cultural inferiority are partly responsible for Hawaiian children averaging below state and national norms academically.
>
> 'Since (Captain James) Cook landed, there have been a lot of putdowns for Hawaiians, and you still see the dregs of it today. Where does it get started? At birth. In the family' (Titchen, 1982 p. A-6).
>
> 'We Hawaiians are an enigma,' says Myron B. Thompson . . . .
>
> 'We are fascinated by our history, though much of it is nightmarish. We are a compassionate people, fiercely proud of our cultural heritage, and we are outraged to see our fragile physical setting — our

> tropical waters, mountains, air, flora, and fauna — being polluted and trampled to death by civilian in-migrants, whose numbers have tripled in the past decade. As a result, too many Hawaiians have a low self-image, Thompson adds. Too many function in a constant state of depression. This state of mental ill-health results in social failure, delinquency, unemployment, and unrealized potential.' (Shaplen, 1982, p.57)

Others have written and testified of similiar feelings:

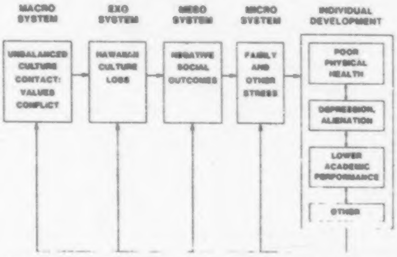
> I come before you today as a young Hawaiian, sincerely seeking constructive ways to remedy the past and redirect the present day plight of Native Hawaiians. The history of the Hawaiian people shows the unjust abrogation of their lawfully constituted government, the unlawful seizure of ancestral lands without compensation, the stripping away of their sovereignty, and the imposition of a more dominant Western culture. A sad feeling of hopelessness and powerlessness followed (late 19th and 20th centuries). Widespread demoralization and disintegration of Native Hawaiians is demonstrated by present day social, economic, and educational statistics. (Keoni Agard, Bill 916 p. 91)
>
> The contemporary problem facing the Hawaiians is a feeling of abnormality in their own homeland, of being at the bottom of the educational and economic heap. (Ogawa, *Honolulu Advertiser*, December 20, 1971)
>
> There is a feeling of hopelessness among most kids. (Henning, 1978a, p. 22)

The recurring theme, then, emphasizes self-disparagement, feelings of inadequacy, fear of failure as well as fear of success, alienation, hopelessness and helplessness, depression. How is this related to academic disparity?

The Culture Loss/Stress Hypothesis

In its simplest form, the Culture Loss/Stress Hypothesis posits the existence of a set of maladaptive behavioral predispositions among modern Hawaiians. This syndrome is hypothesized to relate to the rapid and severe culture loss experienced by Hawaiians since the advent of "western" culture, beginning with the discovery voyages of Captain James Cook in 1778. The syndrome itself is held to include lowered school performance among Hawaiian children and, thus, indirectly as well as directly contribute back to negative social outcomes for Hawaiians. The following diagram graphically depicts this causal chain idea: Implicit within this notion is a feedback loop which makes the cycle self-perpetuating. That is, without intervention, one would expect further cultural disparity, further culture loss, more depression, and increased social failure over time.

FIGURE 32
THE CULTURE LOSS/STRESS HYPOTHESIS



Other Chapters of this report have documented some of these concepts more fully. Chapter II, for example, showed that while laudable gains have been made, lowered academic performance and negative social outcomes continue to be characteristic of the Hawaiian student population. Chapters III and IV presented evidence from a wide variety of sources showing that there **was** historically an unbalanced culture contact and negative social outcomes for Hawaiians. It is the **linking** concept of depression which will be more fully examined here. Several key questions raised by the Culture Loss/Stress Hypothesis will be considered:

1.) How were the historical changes of the past two centuries in Hawaii **experienced** as culture loss by the individual Hawaiians?
2.) What is stress? Can the experience of culture loss cause it? Can it affect academic performance?
3.) What aspects of stress can be found among modern Hawaiians?

The Chapter will conclude with a discussion of what further investigation needs to be done in this area.

1.) How were the historical changes of the past two centuries in Hawaii experienced as culture loss by the individual Hawaiian?

Historians agree that profound changes have indeed occurred in Hawaii since the arrival of Captain Cook in 1778. Social scientists who study acculturation point out that any contact between two cultures will inevitably result in some changes for at least one of the cultures. To the degree that one culture is perceived as more powerful or influential, changes will favor that culture. Usually the process of change involves some degree of alteration in **both** cultures-in-contact. Even cultures in relative isolation change over time. Clearly, for example, "western" culture today is a far cry from that of Captain Cook's time. So the inference of culture "loss" must be carefully made. It must be distinct from simple cultural change to accomodate changing environmental contingencies.

The weight of testimonial data (Chapter IV) strongly supports the notion that many aspects of Hawaiian culture have indeed been lost. Leaving for the moment the "responsibility" for the loss, it seems clear that what was felt and experienced by Hawaiians and non-Hawaiians alike was the systematic suppression of many Hawaiian forms, including language, religion, values, economy, ruling system, and way-of-life. Indeed, the Hawaiian population itself was reduced and almost lost due to introduced disease. Some suggest that this pattern was the result of conscious colonial intentions on the part of foreigners: that Hawaiians were "ripped off:"

> The history of the Hawaiian people saw the unjust abrogation of Hawaiian national sovereignty, the progressive dispossession of Hawaiians from their land, a dramatic reduction of their numbers through disease, and a progressive dilution of Hawaiian culture. (Daniel Inouye, Bill 916, p. 32)

Others point out that the Hawaiians were striving to make the best of a situation leading to inevitable change:

> With their talent for initiating and accepting change, the Hawaiian people were able to adopt, within a comparatively short time, the avalanche of novel things and ways introduced by the Europeans. As the foreigner exalted the worth of his own ways and deprecated the native ways, the Hawaiian people were persuaded to accept basic changes in their life style and as a result lost confidence in the worth of their own culture. (Mitchell, 1969)

Others simply describe the process of loss:

> Gradually Hawaiians concealed their practice or forgot their knowledge of much of their ancient culture. What was remembered would be recalled with increasing distortion. For when a specific practice was discarded or forgotten, there went with it the enduring, often wise concept from which the practice evolved. (Pukui, Haertig, Lee, and McDermott 1979, p. 303)

While there is consensus that a major loss of culture occurred, it is worth noting that this was clearly not total cultural loss. To some extent this is self-evident: there would be no interest in cultural revival today if there were no individuals with knowledge of the culture left. Why some cultural forms were able to survive (chant and dance, for example) while others were not is a study in itself. It should also be pointed out that the modern culture of Hawaii represents changes in "western" thinking which were profoundly influenced by contact with Hawaiian culture. On balance, however, it is safe to say that there was more of an experience of change and loss among Hawaiians over the past two centuries than there was such an experience by "foreigners." It is often remarked that others came to Hawaii from other homelands, whereas the descendents of the inhabitants of these islands regard them as their only homeland, one that has been overrun.

The question remains, however, of how the **individual** comes to realize or feel that something is missing or has been unfairly taken away. In some documented cases it is as direct as a parent telling a child that he or she should not learn to speak Hawaiian, implying that there is something wrong with a part of that family's background. In other cases is seems to be more of a slowly growing perception of something wrong. Consider the following individual cases:

> 'I started out with mixed feelings. I went to Kam Schools and I was proud of that. I studied *hula* — authentic *hula* — and I was proud of that. And at home my father would tell us Hawaiian riddles and stories, but he stopped at that. When it came to anything else, beliefs or old customs, he would tell me — over and over — "Leave Hawaiian things alone. You've got to grow up *haole*."
>
> By the time I went away to college, I wasn't consciously Hawaiian at all. My mainland classmates accepted me. I had lots of friends. But they began pointing out differences in me. They thought I was unusually helpful. I told them about *kokua*. They began to ask all kinds of questions about the way I lived. And for the first time I realized that I *was* different, and I liked the difference. I began to appreciate what I left behind me. So I came home to finish college.'

Home again, Leila began to study Hawaiian at the University of Hawaii and joined Hawaiian study and social groups. . . .

> 'As for me, somewhere along the line a connection was made. For a long while, even after I began to study the Hawaiian language and culture, I thought of myself as segmented. Part of me was *haole*, that part got a graduate degree. That part got ahead. Another part of me was Hawaiian. That part was helpful and warm. But then, finally, the two came together. They are both me.' (Pukui, Haertig, Lee, and McDermott, 1979, p.313)
>
> 'My daughter was so close to my non-Hawaiian in-laws that she thought we Hawaiians were silly. She'd say to me, "Mama, Hawaiians are nuts." Then I took her to Ni'ihau for a visit and she got an idea of the old culture. She said to me, "Mama, these are really nice people. What happened to the people on the outside?" I said, "They (other Hawaiians and part-Hawaiians) are mixed up. You mention something as wonderful as *mihi* and *kala* (forgiving and releasing from bad feelings) to them and they say, 'Oh, leave that alone. That's kahunaism.'"' (Pukui, Haertig, Lee, and McDermott, 1979, pp. 312-313)

These represent "success stories" in that the individuals faced and apparently overcame the forces which were tending to denigrate the Hawaiian aspects of their heritage. Others were not so fortunate:

> Among the Center's (Queen Liliuokalani Children's Center) deeply troubled clients, self-concept as being Hawaiian tends to be negative. Nearly every misfortune or failure is equated with being Hawaiian:
>
> 'The reason all this trouble happens to me is that I'm Hawaiian. There's nothing good about Hawaiians.'
>
> 'It's this way (on welfare) with us because we're Hawaiian. It's not this way with other people.'
>
> A Chinese-Hawaiian boy in trouble with the law: 'It's the bad Hawaiian in me. Why are you trying to help me? I'm a bad Hawaiian kid.'
>
> 'I act this way because of my bad Hawaiian blood.'
>
> 'We didn't give the baby a Hawaiian name. That way, maybe all the badness of being Hawaiian won't go to him.'
>
> 'My in-laws (non-Hawaiian) think I'm just a stupid Hawaiian.' (Pukui, Haertig, Lee, and McDermott, 1979, p.308)

Perhaps no other single event represented "loss" more to Hawaiians, both figuratively and in a sense relatable to everyday life, than the overthrow of the monarchy in 1893 and subsequent annexation to the United States of America. Most modern Hawaiians were not alive then, but many grandparents and great-grandparents were, and the stories do get passed along. And the feelings were very real and very strong.

> About seventy years after annexation at a schoolhouse meeting in Kaaawa, the subject of aloha was being discussed by a mixed racial group. A Hawaiian told of his experience at age seven with the Provisional Government's police force, adding that the republic was a police state then. He remained true to the Hawaiian government till today. (Agard, 1982, p.46)

Concerning this period of time, historian Lawrence Fuchs wrote,

> The essential purpose of the haole elite for four decades after annexation was to control Hawaii; the major aim of the lesser haoles was to promote and maintain their privileged position. Most Ha-

> waiians were motivated by a dominant and inclusive purpose ... to recapture the past.
>
> The present and future appeared devastatingly bleak to the Hawaiians, who continued to decline in numbers due to social disorganization, psychological demoralization, susceptibility to disease, and intermarriage. (Fuchs, 1961, p.68)

There were many individual kinds of responses to events like annexation. One was the active seeking of the culture of the past:

> On the Windward coast of Oahu, in the village of Punaluu, visitors to Hawaii in the 1960's sometimes met a strikingly handsome man, about five feet eleven, whose bronzed and muscular figure was clothed about his loins with the traditional Hawaiian *malo*, this one made of red cloth. David Kaapu, except for his coconut hat and big cigar, was the prototype of the Hawaiian aborigine described in early literature. Vigorous, alert, industrious, full of humor, and hospitable, this philosopher prince of Punaluu brought to life images of the strong men who swam nearly naked to greet the earliest whalers and trading vessels. He was trying desperately to be faithful to the old ways and said, more with sorrow than bitterness, that he had been destroyed even before he was born. (Fuchs, 1961, p.8)

Others simply hid their feelings or withdrew:

> By withdrawing, many Hawaiians kept the haoles from learning how they really felt. But high society hapa-haoles in town could not withdraw. They could only veil their true feelings. One of these, a daughter of one of the last princes — a secret guarded from even her closest haole friends — overstated it this way on the eve of statehood: 'Every Hawaiian holds in his bosom a longing for the monarchy and a deep distrust of the haoles, but our cause is hopeless. What can we do?' (Fuchs, 1961, p.82)

So, presumably, many times over in many Hawaiian households, deep ambivalent feeling became expressed through suppressed hostility towards "haoles," "missionaries," and others, through subtle withdrawal from participation in social opportunities, through hiding of cultural practices, through grudging emphasis on the need to become haole. There are no studies which have measured this phenomenon, but it is not difficult to infer the potential effect on the lives of individual modern Hawaiians.

It may be concluded, then, that the events called "culture loss" have had, and continue to have, effects on the lives of individuals at all levels of the ecosystem. Are these effects contributing to educational problems? If so, how, and with what other outcomes?

2.) What is stress? Can culture loss cause it? Can it effect academic performance?

There is a growing body of research and literature showing that human beings share with other living creatures an innate physiological mechanism designed to protect them from harm. This mechanism reacts to threatening external events by arousing the organism into a state which has been called "fight or flight." The **stress response**, while designed to protect, can itself be injurious to the organism if excessive and unresolved. In other words, **chronic** stress can lead to many forms of physical and mental collapse (Selye, 1956).

The stress concept is not a "diagnostic" one, but rather an explanatory one: chronic or traumatic stress can lead to any number of symptoms including physical disease and behavioral pathology. As such, stress is a "non-specific" concept: in and of itself it does not predict what personal system will experience breakdown, just that breakdown will occur somewhere. Because it relates to the **body** as well as the mind, it implies that where chronic stress exists one would expect to find higher instances of all kinds of disorders. The **form** of the disorders, then, would have to be explained by reference to the culture and individuals in question.

Cross-cultural researchers point out that symptomatology and the experience of mental illness differ dramatically across cultures. Some mental disorders are unique to certain cultures:

> **Pibloktoq**, or arctic hysteria, is found among certain Eskimo populations and is characterized by anxiety, agitation, amnesia, and fear. Oftentimes the victims will take off all their clothes and run naked in the snow. (Marsella, 1979, p. 247)

In Marsella's (1979) review of the cross-cultural study of mental disorders, he points out that culture has multiple effects on both the occurrence and expression of mental disorders. This is because cultures will inevitably differ in their definitions of "normality" and "abnormality," in their susceptibility to different kinds of stress inducers, and in their variations in personality. The rapid culture change or culture loss situation is seen as a significant contributor to individual and family stress. Similarly, feelings of inadequacy or low self-esteem would be expectable when an individual is, for example, trying not to teach her children her own native language but another language instead.

Marsella (1979) lists seven areas in which cultures themselves have been found to be the agents inducing stress in individuals:

1.) **Value Conflict Stress.**
Conflicting values within a given society.
2.) **Social Change Stress.**
Urbanization and modernization can challenge existing means of adapting.
3.) **Acculturation Stress.**
When two different cultures come into direct contact with each other.
4.) **Life Events Stress.**
Events such as divorce, joblessness, etc., vary in frequency across cultures.
5.) **Goal-striving Discrepancy Stress.**
In cultures fostering overly high achievement aspirations.
6.) **Role Discrimination Stress.**
Status discrimination places pressure on lower-status groups.
7.) **Role Conflict Stress.**
Individuals in some cultures have to assume multiple, sometimes conflicting, roles.

Clearly, all of these types of stress, and the overlapping between them, have afflicted the Hawaiians since the first contact with "western" cultures. If these kinds of culture-induced stresses actually do have psycho-social results as suggested here, then one would expect to find similar patterns among other cultures who have experienced similar acculturative or social change events.

Pelletier (1977) presents several such cases. For example, the effects of rapid social change in central India is reported:

> There was increasing upward mobility for a number of Indians living in this area. They were relatively affluent, well nourished, hygienically oriented, educated, and Westernized. In the larger communities, their living conditions were far superior to those of their compatriots living in villages and city ghettos where people were overworked, underfed, uneducated, and not attentive to hygiene. Yet it was among the wealthier Indians that such diseases as diarrhea, ulcerative colitis, neurocirculatory asthenia, and asthma were increasingly prevalent. They were overtaxed by the necessity of adjusting to new values and new circumstances, since they were caught between two social systems and did not find security in either one. Their reactions to this period of excessive change caused them to be tense and anxious, and to exhibit both offensive and defensive protective patterns of behavior. Based upon these observations, Wolff concluded that these people were under constant stress, and that this contributed to their high incidence of psychosomatic disease (Wolff, 1968).
>
> Similarly, Navajo Indians taken from their homes and put onto reservations only a few miles away suffered an appalling increase in mortality from tuberculosis after they had moved (Moorman, 1950). Although the new physical environment was nearly identical to that from which they had come, and circumstances such as food, clothing and hygiene were the same or better, the social disorganization which resulted from the move overburdened the adaptive capacities of many of these Navajos, and they became ill. (pp.84-85)

In the opening section of this chapter we noted the prevalence of a theme characterizing Native Hawaiians as having feelings of hopelessness, despair, inadequacy, self-doubt. These feelings are strongly suggestive of what western psychology and psychiatry call "depression." The term depression has itself been used to describe the Hawaiian condition. Do these concepts relate to the educational needs discussed in the earlier chapters of this report?

It is clear that depression can be conceptually related to lowered academic performance, in fact, in the clinical definition (Diagnostic and Statistical Manual of Mental Disorders III, American Psychiatric Association, 1980) "decreased effectiveness in school" is one of the key behavioral symptoms of depression. There is some debate over whether behavioral disturbance in children is a **direct** manifestation of depression or simply "masks" its presence. For example, Hollon (1970) offered the following conclusion in his discussion of poor school performance:

> Depression in children has received little attention but it is more common than is generally assumed, although it is often masked by other forms of behavior disturbance. A number of children initially referred for psychological testing because of poor school performance were found, upon evaluation, to be suffering underlying depression which was the true source of their school failure. (p. 263)

He also offered the following perspectives on symptomatology and intervention:

> . . . features which can be best described as depressive are definitely evident in feelings of inadequacy, feelings of worthlessness, conviction of rejection by others, and guilt, along with helplessness and hopelessness which undermines all effective effort. (p. 258)

A similar perspective was presented by Friedman and Doyal (1974), whose article also noted the role that social and cultural influences can play in the development of childhood depression.

> . . . Social and cultural influences also must be considered for their possible contribution to the etiology of childhood depression. Low self-esteem, feelings of helplessness, and ultimately apathy derived from an image of the self as helpless in the face of social and environmental structures assuredly must play a contributing role in depression, particularly among culturally deprived and minority group members. (p. 22)

3.) What aspects of stress can be found among modern Hawaiians?

In the case of Hawaiian youth the descriptions offered by social scientists with the KEEP project of students attending the lab school certainly do not match the classic image of depression — the morose, withdrawn individual who has little energy to expend on daily activities. In fact, the exact opposite picture has been painted, as the following excerpt suggests:

> As a group, Hawaiian children are vigorous, socially skilled, talkative, affectionate, and aggressive. None of these traits are surprising; they arise naturally from the peer and sibling-oriented culture. But these traits as manifested in an ordinary classroom can produce chaos; when viewed by a frustrated teacher, they are described in far less complimentary terms, such as 'rowdy, restless, inattentive, lazy, uninvolved, provocative.' (Tharp, 1977, page 16)

It must be emphasized that these observations are **not** those of the "ordinary classroom" teacher. They point out once again how the viewpoint or cultural perspective of the observer is of critical importance in the determination of what is "normal" and what is not.

The beginnings of self-deprecatory behavior may not appear until later in schooling. McNassor and Hongo (1972) point out that:

> Two exploratory studies suggest that Hawaiian children may not feel inferior in academic capability in the elementary school. To the contrary, they show a decidedly strong feeling of academic competence and self-worth. They consider 'haoles' and Japanese inferior to them in terms of being smart in school, in reading, using standard English, using pidgin English, arithmetic, P.E., singing, physical strength, and so on . . . . In the sixth grade, the year prior to junior high school, the children began to express doubt about their academic capability. (pp.5-6).

Certainly if the behaviors described in this summary overview of the Hawaiian child in school are manifestations of an underlying depression, one would have to label them "masked," for they hardly create an image of pervasive depression.

At the same time, however, the point could be made — and it has been, (e.g., Lefkowitz & Burton, 1978) — that developmental variables greatly complicate any discussion of depression among children. For example, behaviors that might be considered indicative of depression at one age may be well within normal limits at another. Thus, it is not inconceivable that the vigorous primary students described above may, after years of teacher disapproval and other aversive consequences, experience feelings of depression that will interfere with their school performance.

Watson (1977), has made the point that "interference effects," or to use the more commonly recognized term "learned helplessness" (cf. Seligman, 1975), can arise when uncontrollable or "non-contingent" stimulation is neutral or even apparently helpful. His research on infant learning suggests that depression, listlessness, and general lack of motivation may result from rearing conditions that provide an abundance of non-contingent input or experience combined with limited experiences in which behavior is responded to contingently. He outlined briefly how a growing middle-class emphasis on "stimulation" of babies might produce undesirable results if this stimulation is largely independent of infant actions.

The connection with Hawaiian circumstances here revolves around the issue of childrearing practices. For example, Sutton-Smith (1977) has noted that peer caretaking, apparently common in Hawaiian families (Weisner & Gallimore, 1977), might be reconsidered in light of what research has shown to be the "positive" (from a dominant cultural perspective) outcomes associated with attentive maternal care. His point was: siblings are probably not as sophisticated in their responsiveness to young children as a parent might be expected to be. This relates to Watson's findings discussed here, and raises a question for consideration: Are sibling caregivers more likely to provide input and experience on a non-contingent basis independent of the responses of young children? And if so, might rearing under such conditions tend to produce "depressed," listless, or disinterested youngsters who have little initiative with respect to school activities?

This question might be extended somewhat to ask about the longterm effects of the teaching style preferred by many Hawaiian mothers. Jordan (1976), for example, found that many Hawaiian mothers use very little verbal direction in interactions with their children in a problem-solving task. Instead they tend to adopt a co-participant role in which they apparently teach through largely non-verbal modeling rather than through a strongly verbal shaping process — the latter being the most commonly observed pattern among Mainland Caucasian mothers. While neither style is necessarily superior, Jordan did report that Hawaiian youngsters whose mothers used more verbal direction tended to perform better in school. In light of Watson's work, meanwhile, one might ask about the longterm effects on affective/motivational dimensions of a teaching style that operates in parallel rather than on a contingent or responsive basis.

Any discussion of stress in relationship to family life among Hawaiians should acknowledge the existence of child abuse. The problem has been discussed elsewhere in this report, with the fact being clearly established that Hawaiians are overrepresented in cases of confirmed abuse and/or neglect. High incidence of child abuse and neglect has implications with respect to stress among Hawaiian youth. In this regard Ritchie and Ritchie (1981) have offered an interesting analysis of the conditions Polynesian women face in New Zealand, conditions which may parallel those in Hawaii:

> For all these caveats, however, there is no denying that, according to the only existing authoritative study for New Zealand, of a total of 252 cases of abuse detected in a single year a staggering 172, or 63 percent, were Maori, Pacific Island, or mixed-race children. Thus, of every three cases detected, two came from an ethnic background that was to some extent Polynesian. In some way, and often within one generation, Polynesians have shifted from a profile of no child abuse to one of high child abuse. What has happened?
>
> . When Maori women become mothers in an isolated suburban setting the situation is generally more stressful for them than for their non-Polynesian neighbors. A number of years ago one of us (Ritchie 1964) reported very high stress scores for Maori mothers in a large New Zealand city. In 1958, when the data were collected, the rates of psychiatric disorder for this category of people were not conspicuously high. Ten years later we obtained identical data for a further sample and again we found evidence of high stress levels and commented that the

> need to attend to this matter was urgent (Ritchie and Ritchie 1970). The stress, which was undifferentiated and very general, represented no recognizable patterning of scores into the usual categories, such as anxiety states, depression, mental breakdown, conversion hysteria, or other neurotic problems. So far as we know, neither in 1958 nor in 1968 was this information utilized in community or mental health services for the population concerned.
>
> Since this stress does not fall into a recognized pattern, it is possible that the usual ways in which stress is reduced are not available to Polynesian migrant women, or perhaps to men (though we have no evidence concerning their stress levels). We postulate that there are patterns of handling stress within Western families which have not yet developed in Polynesian families. The Western woman converts the stress arising from the situation into which she has been forced into neurotic or psychosomatic symptoms, into strategies and tactics in her marriage, into visits to her doctor to procure more Librium or Valium, and increasingly into alcohol dependence (Bernard 1972). The Maori or Polynesian mother simply acts out. None of these strategies are satisfactory, but since we see little being done to provide women with other and better ways of removing stress or coping with it we think Maori and Polynesian women may slowly adopt the same tactics as European women. They may then display less child abuse (or learn to conceal it), but will they really be any better off? The matter, we repeat, urgently needs to be researched (p. 195).

Alan Howard (1974), in his book *Ain't No Big Thing*, explored the relationship of ethnicity to mental health and coping strategies. Using data from the Nanakuli studies (Aina Pumehana), Howard related several measures of "Hawaiianness" to measures of self-esteem, coping strategies, and other social variables. He employed both a Hawaiian Conceptual Test and a Middle-Class Conceptual Test. Overall, the implications of the study are that those individuals who score low on both measures of cultural knowledge tend to also score lower on measures of self-esteem and use less effective coping strategies. Other measures of Hawaiianness (percent Hawaiian ancestry, ethnicity as described by spouse, and cultural self-identity) show a negative relationship with self-esteem and social competence. These would be individuals who fit the description defined earlier of "marginal" people: people who are dissociated from both their original and the mainstream culture. Howard states: "We interpret these data as support for the proposition that knowledge of, and pride in, ethnic heritage is an important if not critical element for the development of social competence among contemporary Hawaiians." (pp. 225-226)

In terms of seeking help, the findings are ambiguous. In spite of testimony to the contrary (see p. 162), the available social indicator data show that Hawaiians are not using mental health facilities in disproportionate numbers (Department of Health, 1982). This is also backed up in a study of the use of Neighbor Island facilities (Mebane, Kamahele, & Carpenter, 1976). This may be partially attributable to the tendency to seek help in other ways. In *Nana I Ke Kumu II*, for example, Pukui, Haertig, and Lee (1972) report that many Hawaiians still seek help from *kahuna* practitioners or folk healers before they would go to a physician or hospital. *Ho'oponopono* (a type of Hawaiian family therapy) and prayer are still commonly used, sometimes in combination with modern medicine:

> The danger that lurks today when some Hawaiians pray and conduct *ho'oponopono* in sickness is that they turn spiritual enablement into 'faith healing.' While prayer can certainly facilitate recovery in many illnesses, prayer should go hand-in-hand with medical diagnosis and treatment. Too many Hawaiians today call in only the minister and forget the doctor. More than one client has said that, 'My *ho'ola* (healer, minister who practices healing) told me not to take the child to the doctor.' (pp. 141-142)

The concept of depression was not an unknown one to the ancient Hawaiians. There are a number of Hawaiian terms which mean or imply the dysphoric mood state and self-deprecatory behavior which is characteristic of depression in its clinical interpretation. (*kaumaha*: weight, heaviness, figuratively sad, depressed; *lu'ulu'u*: bent or bowed down as with weight, sorrow, trouble). Pukui, Haertig, and Lee (1972) report:

> We know Hawaiians of the past recognized the depressed person. He was *loha*, drooping or wilting, 'as a branch hangs low, beaten down, as by rain.' (p. 246)

There may be in modern Hawaiians a **form** of depression which has no specific diagnostic referent. This may even be culturally unique to Hawaiians. It may be less functional to try to fit it into an existing diagnostic category than to simply recognize it as a separate but related phenomenon.

CONCLUSION

Modern Hawaiians seem to suffer from a **new** kind of depression, a being "beaten down," but not by rain, rather, by a sense of enormous personal loss. That this sense of personal loss could be caused by two centuries of rapid change away from Hawaiian culture and could, in turn, partially account for observed academic disparity has been called the "Culture Loss/Stress Hypothesis." This hypothesis has guided the review of theories and findings which can help explain the situation facing modern Hawaiians.

A recurrent theme has characterized recent descriptions of Hawaiian youth: the words "self-disparagement," "low self-esteem," "hopelessness," "alienation," and "demoralization" recur regularly. On the other hand, it was pointed out that the culture loss was not a complete one: that revival of Hawaiian culture has enabled more and more modern Hawaiians to re-establish links with their past.

The concept of **stress** as the underlying mechanism was shown to be a more universal explanatory construct, connecting body and mind with psycho-social forces. The situation confronted by Hawaiians was shown to be similar to that of other groups undergoing cultural stresses.

In attempting to define what stress is, the concept of depression was discussed. While **some** of the symptoms characteristic of clinical depression were similar to the traits observed in modern Hawaiians, others were not. There was not a complete match. A consideration of the cross-cultural meaning of diagnostic categories, however, pointed out that the clinical definition may be culturally limited and thus may not relate completely to the Hawaiian situation.

In support of this concept, data showing that Hawaiians are **not** over-represented in admissions to state mental health facilities was reviewed. It was emphasized that this finding could have multiple explanations, from a reluctance to seek psychiatric help to a lack of recognition of the situation as one requiring help.

What can be concluded? What **does** exist seems to be something similar to clinical depression, but not completely the same. It may be culturally unique to modern Hawaiians even though it was shown to have similarities to syndromes affecting other groups. It does seem to be embedded in a multi-level explanatory system suggested by the ecological model. It cannot be attributed solely to "historical" forces. Neither is it a purely individual phenomenon. The most severe limitation to our understanding may be semantic: we do not have a convenient label which completely fits the situation. It may thus be misleading to call it depression, but there is no other single term to describe it, except, perhaps, *loha*. It may, then, be more effective in terms of planning future research and interventions to center thinking around the concept of stress: of identifying the types of stressors which have affected and are affecting given individuals or groups and of identifying the kinds of physical and mental outcomes which these stressors produce. Specifically, **how can the particular stressors be identified which are most responsible for lowered academic performance, and what can be done about eliminating them or enhancing the capability to cope with them**?

It may be concluded, then, that the Culture Loss/Stress Hypothesis remains just that: a hypothesis which may be most useful in guiding future research and intervention for the benefit of modern Hawaiian students. There are several areas for further investigation:

1) What are the exact behaviors which make up the syndrome in modern Hawaiian young people? Lowered academic performance is there, low self-image, feelings of despondency and of being a stranger in one's own land. Less is known about some of the other symptoms which are related to clinical depression: thoughts of death or suicide, sleeplessness, changes in appetite or

weight, loss of pleasure in normal activities. These should be investigated further.

2) What is the epidemiology of the depressive syndrome? When does it begin? How severe is it for how many people? Why is there no disproportionate representation of Hawaiians in mental health treatment? How much of the real problem is even known about among mental health professionals?

3) Assuming that the existence of the problem is a real and immediate one for many modern Hawaiians, what kinds of intervention strategies might be most beneficial? If the use of mental health professionals is still not highly valued by the community, how can in-culture healers or others generalize their skills to helping more of their own community? Or should efforts be placed in **education** relating to **stress reduction**?

4) What of the many Hawaiians who do **not** suffer from this syndrome? There is evidence of increasing school success, of improving economic conditions, of Hawaiian leaders and potential leaders who are successfully making their way through the macro-system of modern-day America. How can their successes be converted to an image of success for the entire Hawaiian community?

Perhaps the most exciting prospect raised by consideration of the Culture Loss/Stress Hypothesis is that the future does **not** have to be depressing. Others have made encouraging breakthroughs in changing self-esteem through the creative use of modern media (e.g., Johnston and Ettema, 1982). This is what is seemingly needed: to turn around a community's point of view about itself. Many more young people today are able to say, "I am proud to be Hawaiian." In the future, people everywhere should be able to say, "If you want an example of a success story, look at the Hawaiians."

Senator INOUYE. I would like to join my dear friend, Mr. Thompson, in emphasizing, and I do not think we can emphasize enough, that this is not an attempt on the part of native Hawaiians to in any way deny our Indian brothers and sisters any of the benefits to which they are entitled. If at all possible, I hope that this committee will make necessary changes so that additional authorizations can be made to include native Hawaiians and accord them what I consider to be their legal right as native Americans.

I wish to join the committee in thanking you, Mr. Thompson, for being with us today. Your testimony is most helpful, sir.

Mr. THOMPSON. Thank you, sir.

Mr. TAYLOR. Thank you, Senator. The materials will be made a part of the record.

Senator INOUYE. Thank you.

[Subsequent to the hearing the following colloquy took place between Senator Inouye and Mr. Myron Thompson:]

Mr. INOUYE. I would like to take this opportunity to thank you, Mr. Thompson, for your thoughtful and important testimony on S. 277, the Indian Health Care Amendments of 1985. I want you to know that our committee is deeply concerned about the health care needs of all native Americans, including native Hawaiians. If I may, I would like to ask you to comment further on certain aspects of your testimony. Mr. Thompson, you described severe and already-documented health care needs of Hawaiians. What do you consider the highest priorities in terms of these needs and programs to meet them?

Mr. THOMPSON. Senator Inouye, an immediate and pressing need is for more native Hawaiians in the health care professions. The 1980 U.S. Census confirms that Hawaiians are disproportionately absent from these professions, comprising only 4.5 percent of the "Health Diagnosing and Treatment Occupations." This is less than half of the representation of other ethnic groups in Hawaii in these fields. Although these figures are distressing, we are confident that they can be changed. The University of Hawaii's John A. Burns School of Medicine has graduated a total of 43 Hawaiian physicians to date, and currently enrolls 35 in the student body of 274. They, and our other health-related professional schools, are actively engaged in efforts to enroll more minority students. Such efforts, supported by appropriate federal, state, and private funding, can impact on recruitment, preparation for, and completion of health care training among native Hawaiians.

Mr. INOUYE. How much federal assistance would be needed in this effort?

Mr. THOMPSON. We are not talking about a large number of Hawaiian students, Senator. If the number currently attending medical school could be doubled, for example, we would be approaching parity with population percentages.

Mr. INOUYE. Would the provisions in Section 107 of Title I of the Indian Health Care Act, if amended to authorize native Hawaiians to become eligible to receive Health Professions Scholarships, be responsive to this need?

Mr. THOMPSON. Yes, Senator, and I would add that if native Hawaiians could also be included in the Community Health Representative Program (Sec. 108), which stresses the training of native Americans as health paraprofessionals, this would be very beneficial in meeting the other priority need of native Hawaiians, the need for preventive health care.

Mr. INOUYE. Many of the identified severe health problems which Hawaiians suffer seem to be related to the need for early establishment and maintenance of good health habits.

Mr. THOMPSON. That is exactly correct, Senator. Although more research is needed into the causes and treatment of such diseases as lung cancer and hypertension among Hawaiians, there is much evidence that lifestyle change programs, such as in cessation of smoking, weight control, and stress reduction can have direct benefits for native Hawaiians. In fact, we are advocating the implementation of the recommendations in Healthy People, the Surgeon General's Report on Health Promotion and Disease Prevention as the most cost-effective means of meeting native Hawaiians' health care needs. We are most supportive of those sections of S. 277, which include provisions for this. We would emphatically recommend the inclusion of Hawaiians in these sections.

Mr. INOUYE. What is the long-term outlook for native Hawaiians, then, Mr. Thompson? Will these recommended steps be adequate to solve the problem?

Mr. **Thompson**. Senator Inouye, these steps are a worthy beginning. Other recommendations may emerge from the comprehensive needs assessment called for in S. 277. We realize that the larger native American community has many severe health problems and that the Indian Health Service, with the guidance of Congress, is constantly looking for better ways to improve health care. We would welcome the opportunity to enter into discussions with the Indian Health Service, enlisting their aid in seeking further ways to meet the needs of native Hawaiians. It is our hope that by sharing experiences with the other native American groups covered by this Act, the result will be improved health outcomes for all groups. We are confident that the long-term outcome, then, will be an effective federal, state, public and private partnership which will enable native Hawaiians to achieve health status on a par with the rest of the nation. I want to sincerely thank you, Senator Inouye, and the rest of the Senate Select Committee on Indian Affairs for your continued interest in and support for the native Hawaiian people.

Mr. **Taylor** [presiding]. Next, we will take testimony from Mr. Lionel John from the United States and Eastern Tribes, and I would like to call up Adelaide Presley with the Indian Health Inc. of Banning, CA and Barbara Karshmer, counsel for Indian Health, Inc.

Is Lionel John here?

Ms. **Presley**. No, he is not here.

Mr. **Taylor**. Ms. Presley and Ms. Karshmer, why don't you proceed.

STATEMENT OF ADELAIDE PRESLEY, EXECUTIVE DIRECTOR, RIVERSIDE-SAN BERNARDINO COUNTY INDIAN HEALTH, INC., ACCOMPANIED BY BARBARA E. KARSHMER, ATTORNEY AT LAW

Ms. **Presley**. I am Adelaide Presley, director of Riverside-San Bernardino County Indian Health. With me is Barbara Karshmer, attorney. We wish to thank the committee for giving us the opportunity to testify on this very vital and excellent piece of health care legislation.

We are presenting testimony jointly on behalf of our program and Indian Health Council, Inc. Both of our programs are tribal contractors serving 24,000 Indians on 19 Indian reservations in southern California. Barbara Karshmer will be presenting testimony on behalf of both programs on the specific sections of S. 277.

Ms. **Karshmer**. Thank you, and thank you for the invitation to appear here today.

First, I would like to commend the committee on the excellent work that has been done on this bill, especially for its sensitivity to the issues facing tribally operated health programs and its attempts to insure that such health programs are provided equal opportunity to provide health care as the Indian Health Service is given.

We have submitted detailed comments on much of the bill, and I do not want to repeat those, but I would like to stress a few areas of special concern that other groups have not gone into in any great depth.

First of all, I would like to talk about section 712 of your bill, relating to the National Health Service Corps. One year ago, the Riverside-San Bernardino County Indian Health Program, which serves 18,000 Indians, had 3 physicians, 3 dentists, and 1 podiatrist from the National Health Service Corps. These health care providers represented the entirety of its full-time providers and its full-time medical staff. With those providers, they were operating clinics on four reservations and had a fifth clinic about to begin operations.

Since May 1984, the National Health Service Corps has removed two dentists, two doctors, and the podiatrist, so that all that the clinic is left with is one doctor and one dentist who have already received notice that they are to be removed from the program. The program has attempted to obtain assistance from the Indian Health Service to fill these openings or to provide the funds to fill these positions. It has also attempted to obtain assistance from the National Health Service Corps on these problems, to no avail.

Now, the program is faced with severely curtailing or eliminating its Environmental Health Program, its Community Health Program, its Behavioral Health Program including its Alcoholism and Drug Abuse Programs, its Health Education Program, and other services. In addition, it will have to close the clinic on the Torres-Martinez Reservation and will be unable to staff its new clinic on the Pechanga Indian Reservation. It will also have to drastically reduce its contract care services.

I think this latter issue is a significant problem in California because all inpatient care is provided through contract care. This will virtually eliminate the contract care provisions for the 18,000 Indians that are served by the program.

It is also a problem in that the Indian Health Service's own regulations provide that services that are provided through tribes are not to be less than those provided by the Indian Health Service when there is contracting under 638.

The effect of the withdrawl of the National Health Service Corps personnel is to severely diminish the services to the 18,000 Indians within the service population. It is the Riverside-San Bernardino program's belief that this is not how problems are being dealt with by the Indian Health Service when National Health Service Corps personnel are being withdrawn from programs that are operated directly by the Indian Health Service. Entire IHS clinics are not being closed, as tribally operated clinics are. Entire segments of programs are not being terminated. We feel, therefore, that your section 712 is extremely important and should be adopted as it has been proposed and written in S. 277.

In regard, briefly, to your Indian Health Care Improvement Fund, the programs very strongly support the concept. They note, though, a few problems with the Fund as it has specifically been proposed.

First of all, the funding is insufficient to make the changes that need to be made and to provide substantial equality in health care services for all Indians. They also feel that the Fund, as proposed, legislates inequality in that at the end of 4 more years, some tribes will only have 60 percent of their needs met while other tribes will have 100 percent of their needs met.

Since 1980, or long before that, the California Indians have been striving to obtain equality in health care for all Indians throughout the country. In 1980, the 9th Circuit Court of Appeals held that all Indians were entitled to equal levels of health care. Since 1980, the equity fund was implemented. That has certainly helped a great deal, but in 4 more years, roughly 10 years of increased health care, we still will not have a level of health care that is equivalent for all Indians.

So, we would urge that either additional funds be added to that Health Care Improvement Fund or that language be added to address the problem.

The programs are also concerned to some degree about the 15 percent administrative cost ceiling that has been imposed upon all tribal programs. They believe that if such a cost ceiling is imposed, it should be imposed not only for tribal programs operated through 638 contracts but upon all programs, including the Indian Health Service's own programs Tribal programs tend to have higher costs in some areas than does the Indian Health Service because of the need for malpractice insurance, the need to purchase facilities, and other administrative costs that are attendant. The program for backup.

Another area of concern in the Indian Health Care Improvement Fund is the research fund that has been set up with those moneys. First of all, there is not enough money in the Fund to do any substantial research. It is the two programs' feelings that money for research should not come from this Health Care Improvement Fund. It should be sought from another channel.

Just a couple of other issues that I will touch on briefly. One is the issue of alternate resources that we would like to see the committee address. Alternate resources are calculated differently in different areas for the purpose of determining the allocation of resources. They tend to be overstated for the tribal programs and understated for the Indian Health Service programs.

For example, in California, the Califonia Medicaid program, Medical, is factored into the resource allocation for tribes. It is not the actual money that the tribes receive from the Medical program, but it is done as the formula of how many people are eligible for Medical statewide. Therefore, because people statewide may be eligible for Medical when they go to certain facilities, those tribal programs receive less funds because some Indians may be able to go to a county facility and receive care. The fact is they do not go to the county facilities. They continue to come to the tribal facilities, and the programs do not receive the funding to serve them because they are theoretically eligible for Medical if they go to other facilities.

There are quite a number of other examples I could bring up, but I realize your time is short. We would be happy to provide additional information if you like.

I would also like to compliment the committee on its Snyder Act treatment of both the CHR program and the urban program. I think this will help to depoliticize these two programs which have been consistently used as a political maneuvering devices by the administration.

Unless there are any questions, I believe that the written testimony we have submitted covers all other subjects.

[The prepared statement follows. Testimony resumes on p. 309.]

PREPARED TESTIMONY OF THE RIVERSIDE-SAN BERNARDINO COUNTY INDIAN HEALTH, INC., J. PATRICK PATENCIO, CHAIRMAN OF THE BOARD OF DIRECTORS AND INDIAN HEALTH COUNCIL, INC., ROSE HATFIELD, CHAIRPERSON OF THE BOARD OF DIRECTORS, SUBMITTED BY BARBARA E. KARSHMER, ATTORNEY AT LAW, FRAMPTON, KARSHMER & KESSELMAN

The Boards of Directors of Riverside-San Bernardino County Indian Health, Inc. and Indian Health Council, Inc. jointly submit the following testimony regarding the S.277, reauthorization of P.L. 94-437, the Indian Health Care Improvement Act. Both of our programs are tribally-controlled and Indian-administered ambulatory health care providers which operate through P.L. 93-638 contracts with the Indian Health Service, U.S. Department of Health and Human Services (hereinafter Indian Health Service or IHS). Together, our programs serve 24,000 Indians residing on and near nineteen (19) federally-recognized Indian reservations in the rural and remote areas of Southern California. We receive virtually all of our funding from the Indian Health Service. Both programs strongly support the reauthorization of the Indian Health Care Improvement Act and believe that an excellent job has been done in preparing S.277. We are especially pleased with all the attention that has been given to addressing the needs of tribally-operated facilities and programs in order to insure that in service areas such as ours Indians are provided with the full range of benefits that they would receive were they served by IHS directly. Our comments are the following:

I

EQUITABLE ALLOCATION OF RESOURCES

One of the major issues that we request the Committee to address in the reauthorization of P.L. 94-437 is the disparity in health care funding levels that exists among the various tribes throughout the United States. We appreciate the Committee's efforts to eliminate these inequities through the Indian Health Care Improvement fund but we are concerned that the end of four years some tribes will have 100% of their needs met while others will have a 40% deficiency, even if all the funds authorized are appropriated. Certainly such a wide disparity does not meet the requirements of the law. Moreover, we believe that any changes in deficiency levels will more than likely be the result of IHS manipulation of data rather than changes in level of care provided. Our concerns in these areas are based on the recent history of the Indian Health Service (IHS) as viewed by the courts and GAO which we will attempt to briefly explain.

A. The Rincon Case and The GAO Report

The United States Court of Appeals for the Ninth Circuit has held that the IHS has an obligation to expend all the funds in its budget so as to provide an equal level of health care for all Indians throughout the United States. See Rincon Band of Mission Indians v. Harris, 618 F.2d 569, (9th Cir., 1980). In reaching its conclusion, the Court found that the government has an "overriding duty of fairness when dealing with Indians, one founded upon a relationship of trust for the benefit of these . . . dependent and sometimes exploited people." Based on this principle, the Court held that the Indian Health Service has a "continuing obligation . . . to distribute rationally and equitably all of the available Program funds." The Court concluded that IHS had breached its duty to the California Indians "by failing to allocate its limited funds in accordance with a rational distribution standard" and it found that IHS had an obligation to provide Indians in California with services comparable to those provided elsewhere in the United States.

In order to assist the Indian Health Service in implementing the Rincon decision, the Appropriations Committee established an "Equity Fund" which was intended to be a temporary measure to ease the impact of that decision. That Equity Fund, though intended by Congress to merely be an aid in the redistribution of the budget, has turned out to be the sole IHS effort at establishing any sort of equal level of services. When Congress has directed IHS to redistribute portions of its base budget, IHS has either ignored the instructions or has taken across-the-board cuts from all tribes, including those with the greatest unmet need, and distributed that money as Equity money.

The most important factor to understand in regard to resource allocation is that IHS is continuing to use the system which it has always used to distribute funds and which the Court found to be illegal in the Rincon case. That is, the IHS allocates the vast majority of its budget based upon "program continuity", i.e., funding programs at the same level as they were funded during the prior year. The Court in Rincon reviewed this system and held that

> "A system that allocates funds to programs merely because the programs received funds the previous year, regardless of whether the programs are ineffective, unnecessary, or obsolete is not rationally aimed at an equitable division of funds . . ."

The General Accounting Office made a thorough review of the Indian Health Service funding system in the aftermath of the Rincon decision and the Equity Fund. In its report to the Chairman of the U.S. Senate Committee on Appropriations entitled "Indian Health Service Not Yet Distributing Funds Equitably Among Tribes", (GAO/HRD 82-54, July 2, 1982), the GAO states:

> Despite the Rincon case, IHS has not fundamentally altered the way it distributes the bulk of its health care funds to tribes. It still distributes almost all of its funds based on program continuity. About 96 percent of IHS' $594 million fiscal year 1981 health services appropriation was allocated based on tribes' and programs' prior year's funding. The major exceptions to this practice were the equity fund, some congressionally earmarked funds, and certain mandatory cost increases. (p.16).

Based on its review of the IHS funding distribution, the General Accounting Office properly concluded that

> The equity fund, by itself, will not correct the major problems caused by IHS' funding distribution system. (p. 15).

The GAO reaches this conclusion based on the fact that IHS was only allocating 1.3 percent of its FY81 budget through the Equity Fund. It further states:

> IHS is attempting to achieve equity while maintaining program continuity. The equity fund is distributed based on need, but the bulk of IHS health services appropriations are allocated based on the level of the prior year's funding. While maintaining funding of programs may be desirable to IHS, we believe this practice will not lead to an equitable distribution of funds. (p. 15)

Another critical issue that the GAO addresses in its report the IHS claim that it has made significant strides in equalizing the relative levels of care that are being delivered through the use of the Equity Fund. This, however, is simply not true. According to the GAO report:

> "Most of this progress is attributable to IHS' recalculation of tribal requirements for health care services rather than to the distribution of the equity fund." (p. 6)

One example GAO utilizes to illustrate this point is the following:

> When it responded to the Rincon court decision, IHS anticipated needing about $80 million of equity fund moneys to raise all the tribes then in Level V and IV to Level III. IHS gave us information which showed that, based on the fiscal year 1982 analysis of unmet needs, it would take only about $19 million of equity funds through fiscal year 1984 to bring all tribes to a maximum deficiency level of 60 percent (Level III). About $53 million of the $80 million originally planned for distribution through the equity fund was deleted from IHS estimates when IHS changed its method for calculating tribal requirements in fiscal year 1982.

We firmly believe, as does GAO, that IHS has been able to make "progress" in equalizing levels of care by reducing the elements or services which it includes in the benefit package which it funds with equity money, by arbitrarily reducing population figures, by excluding programs such as Community Health Representatives from its calculations, and by simply manipulating its figures. We are concerned that this will be the same result when IHS implements and reports on the Indian Health Care Improvement Fund. Please understand that we strongly support the concepts of the Fund; however, we are concerned about its implementation by IHS.

For fear of underplaying the value of the Indian Health Care Improvement Fund, it is necessary to stop for a moment and explain that the Equity Fund which it replaces, even if flawed, was absolutely vital to our two programs. The Riverside-San Bernardino County Program was able to increase its services from 31,676 patient visits to 95,705 direct care patient visits, 13,816 contract care visits, 1,221 days of inpatient care and 22,000 lab visits after only two years of Equity Funds due largely to its ability to provide needed services that were not previously available to the service population. Programs such as optometry, community health nursing, nutrition, health education, mental health, expanded dental and medical care, and other similar services are being provided for the first time to the 18,000 Indians in the service area. In spite of these advances, 74 percent of the health care needs of the Indians in Riverside-San Bernardino County Indian Health, Inc.'s service area remained unmet. Similarly, Indian Health Council was able to double the number of its patient visits with the Equity Fund and can now provide a full-time doctor, an added dentist, an optometry program, an alcohol and drug abuse program, mental health care, audiology services, and some limited specialty care.

B. Cutbacks in Availability of Alternate Resources

Indian Health Service funding is becoming ever more crucial to our health programs with the recent cutbacks in funding from the State of California, cutbacks in the National Health Service Corps, and changes in the state laws regarding regarding Medi-Cal reimbursement. Although the state previously provided a very limited amount of funds directly to the Indian health programs in California to supplement the IHS funds and also provided various categorical grants, these funds are now being given to the counties in block grants and are no longer directly available to meet the needs of the Indian people. In addition, changes in Medi-Cal regulations now require individuals to obtain treatment at county hospitals or from certain contract physicians, most of which are totally inaccessible to the Indian reservations. Previously, our Indian clinics could treat these eligible individuals and receive reimbursement from Medi-Cal to supplement their meager budgets. Now we cannot.

One of the major problems with IHS' implementation of the Equity Fund which we are concerned will continue with the Indian Health Care Improvement Fund is that there is a time lag of one to two years in correcting and updating the data that is used to calculate the distribution. Due to changes in the Medi-Cal program, there has been a tremendous cut in eligibility for individuals and in the rates which are paid to medical providers for services, as noted above. In addition, the State of California has cut back on virtually all of the supplemental health programs which the clinics have utilized, or has switched to block grants which the Indian tribes cannot obtain. Similarly, senior citizens are being charged for Medi-Care which they are unable to afford, so have no health coverage; and the S.S.I. recipients cannot afford to pay the premiums for Medi-Cal so are no longer eligible. And, the National Health Service Corps is removing its Indian placements in California which has already resulted in a loss to the Riverside program of three of its four full-time physicians, three of its four dentists, and its only podiatrist. IHS has been unwilling to alter its resource allocation to assist the Riverside-San Bernardino Program to make up for these substantial losses even though IHS was asked to assist more than one year ago. Thus, while third party sources of revenue are rapidly diminishing, we expect that it will take at least two years for IHS to take these immense decreases in available resources into account in distributing any Health Care Improvement Funds if prior experience is a guide.

In addition, the Indian Health Service has reduced our need for funds in calculating the Equity Fund distribution by determining that a certain percentage of the population statewide is eligible for Medi-Cal and reducing our need by that much rather than utilizing our actual Medi-Cal reimbursement figures. This becomes especially inequitable when one considers that not all clinics can obtain reimbursement from Medi-Cal and that elegible Indians often have no other resources available, acceptable, or accessible to them. This problem will likely continue with the Health Care Improvement Fund.

C. Utilization of Workload Data

Another problem which we face in the allocation of funding is caused by the fact that workload data is reported differently in California than elsewhere, creating an impression that fewer services are being delivered. We request that a provision be added to the Act to require IHS to develop and utilize uniform data reporting systems so that all areas will be treated equally. Although Section 601 appears to address issus of statistics and data, it is not clear that it will specifically address this issue.

Moreover, the IHS proposal to and partially implemented practice of basing allocations on past workload is unfair for those programs which have not had substantial funding in the past because patients could not receive care if there was no funding to provide that care. Until there is full funding available, those facilities will be unable to generate workload data to justify further funding. So, we are left with the old question of the chicken or the egg. Without sufficient funding, the program will not be able to provide services and thus workload data will be limited; and, conversely, without workload statistics, the programs will be unable to justify additional funding. Therefore, we urge that population figures be used instead of workload data in those areas, such as California, which have been chronically underfunded until such time as adequate funding is obtained and realistic workload data can be generated. The importance of this issue cannot be overemphasized.

The Indian Health Service began it use of workload data for distribution of resources this past year when it distributed about $40 million in program increases which it received in the FY84 budget. Using a wholly different formula than the Equity Fund utilized, and basing distribution largely on workload data, the Indian Health Service gave less than 4 percent of the funds to California, although California has more than 10 percent of the Indian population in the country.

An excellent example of the problems created is that there are about 4,300 Indians living in poverty in the high desert area served by the Riverside-San Bernardino County Indian Health program who are 135 miles from its nearest health facility. Because of the distances involved, we are unable to provide any substantial services to these Indians who are in severe need of health care. Until we receive funds for facilities and for services to reach these Indians, we will not be able to provide them with the necessary services. They will, therefore, never be served if current workload data or patient registration is used as a basis to distribute funds.

Based on the above considerations, we urge the Committee to include language in the reauthorization of the Indian Health Care Improvement Act directing and requiring the Indian Health Service to provide an equal level of care to all Indians based on factors such as population, costs of providing care, etc. And, we urge that the Indian Health Service be directed to make the full range of services available to all Indians, not just some. Equity Funds have in the past been provided for only a limited range of services, whereas those tribes which have historically received a higher level of funding are presently able to offer a greater range of services than those provided through the Equity Fund. In addition, we are not provided with any funds for the administration of our increased programs. Surely this is not the "fairness" that the Courts have long held to be due the Indian people. Please assist us in rectifying this situation.

D. Indian Health Care Improvement Fund, §201

In regard to the Section 201 establishing the Indian Health Care Improvement Fund, we have some serious concerns about this proposal although we strongly support its intent. First, we believe that there must be language added to the Act to specify that all tribes are entitled to receive health care services that are comparable in quantity, range, and quality of services provided. Much of what the Indian Health Service had done to date is to provide a limited "benefit package" for health care services through the Equity Fund. This benefit package varied from year to year at the whim of the Indian Health Service which tried to downplay the extent of unmet needs and did so in part by manipulating what it included in the benefit package. At various times, the benefit package excluded such services as emergency services, preventive health service, community health representatives, etc. It regularly excluded funds for administration of the programs and funds to maintain and repair the facilities. We believe that your inclusion of all these areas of concern go a long way toward alleviating this problem.

We believe that the proposed language in §201 legislates a continuing inequity in the provision of health care services because it validates the Indian Health Service practice of utilizing "program continuity" as its major means of allocating funds and allows the Indian Health Service to continue funding disparities of 60 percent to 80 percent for several more years. It does this by giving the Indian Health Service four more years to raise all tribes to the point where they have a deficiency of not more than 40 percent of the total resources they need. In the meantime some tribes will have 80 percent more of their needs unmet while others may have only 10 percent of their needs unmet. Section 201 provides that by the end of 1990 all tribes should have a minimum of 60 percent of the funds they need to deliver health care to their members. However, once they have reached this level, there will still be a variance of 40 percent among the tribes as to what level of care they will be receiving. Some will be receiving 100 percent of the services which they need while others will be receiving only 60 percent of the services which they need. This is hardly the equitable division of funds mandated by the Court in the Rincon case. Granted, it takes some time to accomplish the results mandated by the Court in the Rincon case, but having a 40 percent disparity remaining at the end of seven years of the Equity Fund is not, we believe, an acceptable result. It must be noted that, while there are disparities in funding levels in other areas, it is California which suffers the brunt of the funding disparities and, as a whole, continues to have the highest levels of unmet need in the country at present.

Instead, we urge that the findings of the court in Rincon and the GAO in its report be mandated into law by requiring that IHS, in the words of GAO:

> -- Abandon its longstanding practice of funding programs based on the previous year's funding level (program continuity).
>
> -- Use standards and criteria for distributing all of its health services appropriated funds.
>
> GAO Report, supra, at page 15.

In regard to this latter recommendation, we urge that the Indian Health Service be required to utilize one allocation formula for all of its funds, not different formulas for different pots of money as it presently does which furthers the inequities. We also request that IHS be instructed to utilize census population figures rather than utilization figures in those areas such as California which have never received an equitable level of services, until such time as at least 80 percent of the needs are met and there can be a rational determination of the actual user population.

II.

FACILITIES NEEDS

A. Facilities Construction, §301.

In the reauthorization of the Indian Health Care Improvement Act, we applaud the inclusion of requirements that the Indian Health Service be required to fully review the needs for inpatient and outpatient facilities (including renovation and expansion of existing facilities) for tribally-operated programs. We can testify to the wisdom of this approach because our facilities are, as are most in California, severely overcrowded and in need of expansion and renovation. However, our facility needs have never been fully analyzed or seriously considered by the Indian Health Service.

We request that the Indian Health Service be required to fund a minimum of ten inpatient and ten outpatient facilities rather than leaving the decision to IHS in §301(e) for IHS has rarely, if ever, included outpatient facilities in its priorities. And, a severe need for expansion and renovation of outpatient facilities has, to our knowledge, never been sufficient to place a facility on the priority list. Without question, it is more cost effective to do minor renovation and expansion than to wait and replace the entire facility as the IHS system currently encourages. We believe that there should be a separate fund of money specifically set aside for renovation and expansion so that these needs do not have to compete with needs for new hospitals.

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B. Sanitation Construction, §302

In regard to the sanitation construction provisions found in Section 302, we support the requirement that the Indian Health Service confer with each tribe and tribal health provider to determine their perception of their needs prior to submitting the report of such needs to Congress pursuant to Section 302. It is our feeling that the other provisions such as those for emergency and technical assistance funds, those relating to transfer of the systems, and those allowing P.L. 93-638 Contracts are very important and valuable. The only thing which we would suggest adding to the section on sanitation would be a provision that the facilities priorities be determined based on their compliance with tribal regulations as well as Federal laws and regulations.

III.

MISCELLANEOUS PROVISIONS

A. Eligibility Provision for California and California as a Contract Care Area, §705 and §706.

Because of the unique history of the Indians in California which results in large part from the failure of Congress to ratify all the treaties made with the California Indians in the 1850's and from the attempted termination of a large number of the tribes in the 1950's, we support the definition of eligibility in California set forth in §705. We also support the provisions of §706 making California a Contract Health Service Delivery Area.

B. Contract Health Facilities, §711(a)

We strongly support the provisions of §711(a) because it has been our experience and, we believe, that of other tribes contracting under P.L. 93-638 (the Indian Self-Determination Act) that tribally-operated health programs are not treated the same as IHS' own Service Units. For example, tribal clinics are not provided with funds for maintenance and repair, for training of their staff members, or for facilities; nor are they given IHS positions, supplemental appropriations and mandatory cost increases (including the equivalent of pay act increases). Similarly, they are not provided with funding in all the categories in which IHS gives monies to its own service units. This provision should remedy these problems.

C. Catastrophic Health Emergency Fund, §202

We believe that, instead of establishing and funding a national catastrophic emergency fund, the money proposed for this purpose should be added to the base budget for contract care each year. The fund, as proposed, is good in concept but the possibilities for mismanagement are sufficient to persuade us that it ought not to be adopted. The problems we see with this fund include the lack of criteria for use and lack of definitions of catastrophic health disasters or illnesses. We are concerned that the Indian Health Service may use the authority granted herein to promulgate regulations defining such disasters or illnesses as the first step in implementing the clinical care priority system which it has proposed through its Contact Health Services Task Force Report. Specifically, we see the possibility that the Indian Health Service will then mandate that only those illnesses and catastrophies which it lists for use of funds may be treated and that those may be treated only with moneys from this specific fund, thus limiting the uses to which contract care moneys may be spent. Instead, tribes should be allowed to decide for themselves which services they want to provide and they should be able to determine for themselves what their health care priorities should be. These priorities may vary from one part of the country to another.

D. Health Services for Urban Indians, §501 et seq.

We support the continued provision of health care services for urban Indians and we support the inclusion of a reference in §502 to the Snyder Act being the authority for these programs inasmuch as these programs were originally initiated under that authority.

E. Indian Health Services as an Agency of the Public Health Service, §602 et seq.

We support the concept of elevating the Indian Health Service to the position of an Agency within the Department of Health & Human Services.

F. Leasing and Other Contracts, §701

We strongly support the inclusion of this section in the Indian Health Care Improvement Act.

G. Juvenile Alcohol and Drug Abuse, §702

We believe that this is an important area and are pleased to see that it has received special attention in the bill.

H. Service to Ineligible Persons, §713

We agree with these provisions in general, but are a little conerned about Sections (b)(2)(A) and (B). Our member tribes believe that each tribe's sovereignty might be abrogated by these provisions and even a 50% majority of the tribes should not be allowed to make the decision for other tribes as to whether ineligible persons will be served. That decision should be left to each tribe on a tribe by tribe basis.

I. Restrictions on the Use of Funds, §714

We firmly support the inclusion of these provisions in the legislation.

J. Community Health Representative Program, §108

We support the inclusion of these provisions and appreciate the

Committee having given special recognition to the importance of this program in delivering health care to Indians. We also appreciate the clarification that this program be supported under the authority of the Snyder Act, a fact which should make it more difficult for IHS to delete CHR's from the overall program.

K. Health Promotion and Disease Prevention, §204

Our programs applaud the inclusion of these provision in the Bill inasmuch as we believe that preventive health services are the most cost-effective means of delivering health care. We are extremely pleased to see the provision of these sections for they establish as federal policy a portion of our health care delivery programs which IHS has repeatedly attempted to eliminate from the benefit package it provides to Indians. We believe that this is one of the most important areas to include in the services provided by IHS.

L. National Health Service Corps, §712.

The provisions relating to the National Health Service Corps (NHSC) are of extreme importance to Riverside-San Bernardino County Indian Health, Inc. because we have always been entirely dependent upon the Corps for all of our primary care providers. Specifically, one year ago all three of our physicians, all three of our dentists, and our one podiatrist were NHSC placements. Since May of 1984 we have lost two of the physicians, two of the dentists, and the podiatrist. The one physician and one dentist that remain have received notice that they too are about to be moved. Considering that we operate clinics on four different reservations to serve 18,000 Indians, the gravity of the problem becomes evident. Although we have been asking both IHS and NHSC to assist us in dealing with this problem for the last year, all that has resulted is that positions have been removed and we have had to absorb the losses on virtually all of our full-time providers by cutting other parts of our program. At present we are faced with severely reducing our preventive health program for the eleven reservations and 18,000 Indians we serve by curtailing or eliminating our environmental health program, our community health nursing program, our behavioral health services department (including our alcoholism and drug abuse programs), our podiatry services, and our health education program. In addition we will most likely be required to close our clinic on the Torres-Martinez Indian Reservation and will be unable to staff or equip our new clinic on the Pechanga Indian Reservation. Moreover, we will have to drastically reduce the provision of contract health care services to eligible Indians which is especially problematical because all inpatient services have to be purchased through the use of contract care funds since there are no Indian Health Service hospitals in California.

This is especially serious in light of 42 C.F.R. §36.202 which requires that the services to be provided to Indians not be diminished as a result of tribes contracting under P.L. 93-638 to provide those services themselves. We believe that the Indians whom we serve would not be faced with these drastic reductions in care if we were not operating through a P.L. 93-638 contract, because the Indian Health Service has made the necessary adjustments to continue the provision of care in areas in which it itself provides the health care without reducing or eliminating whole segments of its health care program. Moreover, to the best of our knowledge, the Indian Health Service has not closed entire clinics because of the loss of National Health Service Corps providers.

The provisions which you have proposed are vital to insuring that this problem is remedied and that it does not occur again. Although we have repeatedly requested IHS to deal with this problem for more than a year, nothing has been done to date and we have lost five our our seven full-time primary care providers. IHS has so far refused to provide us with the funds to make up for these losses so we are being forced to eliminate many vital segments of our program to allow us to provide primary care. Thus, all the immense progress we made through four years of Equity funding is being taken away through the refusal of the NHSC and IHS to resolve this problem. We believe that the root of the problem is that the NHSC believes IHS is the primary provider for Indians and should be funding these positions while IHS believes that it is the residual provider and will not provide funding because the NHSC is an available alternative resource to us. No matter who is correct in their political posturing, it is the Indians we serve who are being forgotten as the recipients of much needed medical care.

We, therefore, urge that §712 be adopted in its entirely as proposed. It exactly addresses the problem we face and does so in the best conceiveable way. We heartily endorse its provisions.

IV

ADDITIONAL RECOMMENDATION FOR INCLUSON IN THE INDIAN HEALTH CARE IMPROVEMENT ACT

A. GAO Review of Resource Allocation.

We urge that the General Accounting Office be requested to provide a review of the Indian Health Service's resource allocation methodology and report back to Congress on the methodology and the progress being made on equalizing the care provided to Indians throughout the United States.

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B. Contract Health Services Task Force Report Recommendations.

We believe that the suggestions made by the Contract Care Task Force report in regard to eligibility for services, blood quantum requirements, clinical priorities, service delivery areas, etc. should not be implemented because they create a major deviation from existing policy and are being carried out without sufficient consideration or even knowledge of their potential consequences. Moreover, there has been little or no opportunity for serious input from the Indians themselves on these issues. We urge that the Indian Health Service be mandated not to implement any of the recommendations in the Contract Health Services Task Force Report until such time as each policy therein is fully reviewed by Congress and approved for use.

CONCLUSION

We wish to thank the Committee for the opportunity to present our views on the reauthorization of the Indian Health Care Improvement Act. We realize that the foregoing comments are lengthy; however, this Act is of vital importance to the members of the tribes which we serve and we felt it necessary to address all of their concerns.

We shall be more than happy to provide you with any additional information which you may request and to answer any questions which you may have about the subjects we have addressed herein.

Thank you for your thoughtful consideration of these comments.

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Mr. **Taylor**. I thank you very much. I do not believe we do have any questions. It is certainly a good statement.

Ms. **Presley**. Thank you.

Ms. **Karshmer**. Thank you.

Mr. **Taylor**. Next, we will have Mario Gutierrez and Joseph Saulque, both of the California Rural Indian Health Board.

STATEMENT OF JOSEPH SAULQUE, CHAIRMAN, CALIFORNIA RURAL INDIAN HEALTH BOARD, ACCOMPANIED BY MARIO GUTIERREZ, EXECUTIVE DIRECTOR

Mr. **Saulque**. I thank you, Mr. Chairman. Again, I would like to thank the committee for working with the tribal health programs and the tribal governments in developing S. 2166. We would also like to especially commend Paul Alexander and Patricia Zell for their unselfish work and effort on this bill, especially on finalizing S. 277, which is a waste of time, actually, when it should have been passed last year.

It is with pleasure that we come before you again and provide you with our testimony on S. 277 on behalf of the California Rural Indian Health Board and its member tribes and tribal health programs. We are gratified that this committee has given top priority to the early passage of this bill and remain committed to the health care needs of the nation's Indian people.

In our review of the bill before you, we completely concur with the approach of the committee to eliminate only the two objectionable provisions from the proposed law while leaving the remainder of the amendments and provisions substantially intact. We are prepared to accept in good faith, as apparently you do, the position of the President in his veto message that, without these two provisions, S. 2166 would have been signed into law.

We believe the record of testimony by CRIHB on the reauthorization of this Act during last year's proceedings reflect our current position on all specific titles under consideration. We are in complete agreement with the final version of S. 2166 with the exception of the two issues already mentioned, which are the Montana provision and the commission on elevation of the bureau.

We would, however, wish to make further comment on the amendments and provisions which relate specifically to Indian Health Service funded services in California. Our positions were formulated only after numerous and extensive consultation with the 27 tribes that we serve or are represented by the CRIHB Board of Directors, and our 13 member programs, and other independent tribally operated contractors in the State.

With that, I would like to turn it over to Mario to be more specific on those issues.

Mr. **Gutierrez**. Thank you, Joe, and members of the committee. As Joe said, the provisions that are included for California were developed through extensive consultation with the tribal governments and with other 638 contractors and legal experts within the field. We do appreciate the committee's and the staff's intent in again including all those provisions in S. 277 intact as they were passed in the previous S. 2166.

I would like to focus my brief comments here on the two areas that were mentioned in the veto message by the President, since it appears that both of those still have some considerable controversy and interest on behalf of members of the Senate Select Committee.

The first issue, that is the whole question of the elevation of the Indian Health Service, I do not think we could have a better example than what we had this morning with Dr. Graham's presentation as to why we need to see that position elevated and the Indian Health Service removed from that agency. I think his polite arrogance, which is the best term I can come up with, toward this committee, toward the Congress, and toward the Indian tribes is clearly evident in the way he approached his testimony. It was really a shame, I think, that when we have the first Indian Director of the Indian Health Service, Dr. Rhoades, to sit idly by and not be himself accountable and responsible for providing the testimony and speaking on behalf of the tribes and the Indian Health Service, to me, is a clear example as to why we have to see that whole agency removed from the HRSA bureaucracy.

In regard to his comments dealing with the questions of contracting and procurement, again, it shows a clear lack of understanding by HRSA and Dr. Graham as to what the Indian Health Service and, in particular, tribal P.L. 93-638 contracts were meant to do. I think Congress was very specific when they passed that law that they intended that responsibilities be transferred all or in part, as the tribes request, to tribal governments. They are not purchasing services from Indian tribes. It is a partnership, and that partnership includes responsibility without the patronizing approach of the HRSA administrator to be looking over our shoulders to see that we are spending our money properly and getting our competitive bids and such.

We can provide quality health care. We can provide it efficiently, cost-effectively, and, I think, in many ways better than the Government can do, if they would just allow us to do it without the overlay of bureaucratic regulations that go with the procurements and contracting under the HRSA system. So, if for any other reasons, I think for that consolidation of personnel, contracting, policymaking, et cetera, we feel that the Indian Health Service should be elevated. As to the question of whether it should be an assistant secretary or an agency level, I think we leave up to the discretion of the committee to work out as to what is most appropriate, but I think the effect of what we are trying to achieve is understood by both the Senate and the House respective committees, and we urge you to insure that remains intact.

In regard to the Montana provision, it seems clear from Senator Melcher's comments this morning that he intends to proceed further with that inclusion, either through amendments at the committee level or through the conference committees. We can not help but agree with the Senator's position that the Government does have an obligation to the Indian tribes of this country over and above the general citizenry obligations. However, how far that obligation goes in terms of the relationship to the dollars being appropriated, I think, is a big difference.

We are approaching it from the perspective that we agree that there are rural hospitals out there, rural providers on the county level, that are being put upon to provide health services that the Government should be providing. But when you look at the Indian Health Service's own accounting of what will be required based on the tribal specific health plans, they estimate that it would be somewhere in the neighborhood of $3 to $4 billion. That is 400 percent more than what is currently available under this 1986 appropriation request before the Congress.

So, what are we talking about? If, in fact, we are going to be moving toward obligation if not entitlement, which is a whole other can of worms, is the Congress prepared, and is the Senate prepared, to back us up in terms of the allocation and appropriation for the Indian Health Service? Because, that is what it really means.

In California, we have just $500,000 in contract care for the entire State. That is less than 1 percent of the entire contract care budget for the entire country for a State that does not have one IHS hospital providing care to Indian people. We have to purchase all of our important and specialty care through contract care, yet we have less than 1 percent of the budget for contract care with over 65,000 Indian people eligible.

However, if that is the case, the way the Senator has put it this morning so eloquently, then our budget for California is going to be bankrupt in less than a month if we have to depend on what he is proposing. What is right for the situation in Montana should be appropriate for the rest of the country. It should not be a special provision for Montana, but it has to be backed up with funding.

Finally, on the question of the issue of the CHR program and the administration's position that these are fringe programs that do not provide primary care, again, it shows a real lack of understanding of what is happening out in Indian country with health care. The CHR's are the direct link between the Indian community and the providers and are probably the most cost-effective, beneficial program that the Indian Health Service has going for it. Yet, it is ironic that this is the first place they look for cuts.

So, when they talk about putting their priorities in health promotion, prevention, looking at long-range health care improvement, they do not back it up with their actions. Just by cutting out this one program, it shows that they are not seriously interested in health promotion. It is again a real arrogance on the part of the administration.

Again, we commend you for putting in that specific provision, which, by the way is something that we have always agreed with that authorization for this program is provided under the Snyder Act. We did not realize that there even existed any question about that, but it is good to make it explicit, and we will support the committee in these efforts.

I am sorry that the Senator from Montana could not be here to hear the comments from the tribal people from around the country in regard to this most important item. We know it is very important to him and his constituency. In keeping with the philosophy of the Senate to try to reach consensus on all issues, we hope that the Senator can find it within himself to be an advocate for all Indian tribes and work with the committee and with the House to resolve this issue.

Thank you.

[The prepared statement follows:]

PREPARED STATEMENT OF THE CALIFORNIA RURAL INDIAN HEALTH BOARD INC., SUBMITTED BY MARIO GUTIERREZ, EXECUTIVE DIRECTOR AND JOSEPH SAULQUE, CHAIRMAN OF THE BOARD

The California Rural Indian Health Board, Inc., which represents the largest Indian Self-Determination Act tribal health organization in the state, is on record with this committee and the Congress as a strong, and vigorously active advocate for the reauthorization of the Indian Health Care Improvement Act and its related amendments.

During most of 1984, CRIHB worked closely with the Senate Select staff and their counterparts in the House to develop a piece of legislation that not only outlined a structural plan for the continued development of health and related services for the nations' native Indian people, but also provided a clear statement of principles and policy to guide the joint partnership of the federal government with the tribes in improving our quality of life and making lasting improvements in the general health status. We were especially pleased that, during the course of its development, S.2166 underwent considerable scrutiny, lively debate among the tribes, countless revisions, and finally emerged as a bill which was generally acceptable to most of the Indian tribes and organizations in the country. Consequently, we were bitterly disappointed with the Presidential veto of October 19 which has left this administration's policy on Indian Health in a state of limbo and confusion. Despite this setback, we agree with the position of the President that the so-called "Montana provision" and "elevation commission" were objectionable, though we disagree that they were "totally unacceptable" thereby necessitating a veto of the entire bill.

In our review of the Bill before you, S.277, we completely concur with the approach of the committee to eliminate these two objectionable provisions from the proposed law, while leaving the remainder of the amendments and provisions substantially intact from last years S.2166. We accept (as apparently you do) the position of the President in his veto message on good faith that, without these two provisions, S.2166 would have been signed into law.

On the issue of the "Montana provision" we wish to go further and state that we view it as a dangerous precedent and has the potential for weakening the tribal trust responsibility as it relates to the provision for health care. We recognize that this is an issue of some importance to Mr. Melcher and represents the concerns of local government in his state. We can only implore the Senator to weigh in balance his responsibilities to the nation's Indian people as a member of this committee and strive with all of us to resolve this issue through other alternate means to prevent any further delay in the passage of this important Act. We oppose any attempt to introduce this either as an amendment or in the joint conference, since the President has made his position clear on this issue.

In regard to the issue of the elevation of the Indian Health Service to an "agency level" within the Public Health Service, we feel that this is a necessary and appropriate step, although the actual level of the IHS within the Health and Human Services bureaucracy is not as important to us as the effectiveness of that agency in the management of its resources, its contracts and its development personnel under the exclusive authority of the director of that agency. In addition we feel it is vital that the director of IHS be in a position to establish sound and effective policy, have accessibility to the Congressional authorizing and appropriating committees, and be able to insure that the resource and policy requirements of the nations' Indian people receive the special and separate attention required under the law. We concur with the proposal to delay until May, 1987 the enactment of this provision to allow for a plan to be submitted by the Secretary to the Congress which takes into account all relevant studies and information, particularly the Office of Technology Assessment of the Congress. Hopefully this will insure a smooth and orderly transition. With a budget approaching $1 Billion, it is clear to us that the Indian Health Service is now a major agency within government, and represents the largest federally operated health service outside the military. As a tribal contractor under the provisions of PL 93-638, operating eight service units, we particularly share the frustration of the IHS administration of having our hands tied by the incessant layers of bureaucratic approval and oversight. This is concept whose time has come.

I believe the record of testimony by CRIHB, Inc. on S.2166, both oral and written, reflects our position on the specific Titles which have now been reintroduced, and we will therefore only state at this time that our positions remain virtually the same, and, we are in concurrence with the final language which is reflected in S.277.

In particular we wish to make some final comments on the amendments and provisions which relate specifically to the IHS funded services in California. Our position was formulated only after numerous and extensive consultation with the twenty seven tribes served or represented by the CRIHB Board of Directors, our thirteen member programs, and other independent tribally operated contractors in the state. To be sure, this is not the unanimous consensus of the tribes of the state, but does reflect, in our opinion, the will of the vast majority of the beneficiary Indian population of the state.

1. SECTION 705

CRIHB supports this section, the purpose of which is to codify existing IHS practice by putting eligibility of California Indians on an equal basis with other Indians and to eliminate the possibility that future administrative changes could drastically reduce the eligibility of California Indians, the majority of whom are not enrolled members of federally recognized tribes. This section does not affect the eligibility of non-California Indians, whose eligibility would continue to be determined, as it is elsewhere, by IHS regulations at 42 CFR 36.12.

This interpretation of § 705 is confirmed by the unambiguous language of the section itself, which, on its very first line, expressly states that it applies only to "California Indians". In addition, the House-Senate Conference Report accompanying S.2166, the purpose of which is to explain the intent of the Bill's provision, explicitly states that "the purpose of this provision is to codify existing IHS policy and practice with respect to the eligibility of California Indians for IHS services."

Finally, § 705 is virtually identical to the earlier version first proposed by the Energy and Commerce Commission in the House. It is therefore instructive to note the Energy and Commerce Committee language explaining the purpose of this section, which makes it abundantly clear that the rationale of this amendment was to clarify the eligibility of California Indians. It states:

> The provisions can only be understood in historical context. When Congress in the 1850's was first presented with treaties that the federal government had entered into with Indian tribes, it failed to ratify them. Members of tribes whose treaties were not ratified were eventually recognized as "Indians of California" for purposes of compensation. Some were given allotments of public lands instead of tribal status, others were belatedly recognized with the creation of rancherias for homeless Indians, only to have their status terminated a few decades later. Still others were placed on reservations and today remain members of federally recognized tribes.
>
> The purpose of this amendment is to identify each of these categories of California Indians each of these categories of California Indians by reference to objective criteria which are readily ascertainable . . . The Committee amendment is intended to protect members of the IHS service population from any loss of elibigility as a result of any potential future administrative changes.

Since this rationale obviously has no application whatsoever to non-California Indians, it makes little sense to conclude, as Mr. McCloskey apparently does, that this Amendment could affect the eligibility of Navajos living in California.

2. SECTION 706

CRIHB supports this section because it would eliminate the current confusing situation under 42 CFR 36:22-23, in which eligible Indians who reside in the service area of a tribal program, but do not reside in or adjacent to a county with a reservation in it, are eligible for direct care but not contract care. This anomaly is a result of the application of the current contract care regulations to the peculiar situation in California, as described above by the Energy and Commerce Committee, in which many of the eligible Indians live in service areas composed of counties without any land base.

At the Auburn Indian Health Program, for example, current regulations, if enforced, would mean that since the only tribe in the service area is in El Dorado County, Indians living in Sierra or Nevada counties would be ineligible for contract care. Similar problems exist for most of the CRIHB Sub-contractors such as Tuolumne Rural Indian Health, Northern Valley and Central Valley. These problems would be eliminated by this Amendment, which makes all rural counties in California CHSDA.

This provision would also make it possible to expand the contract care system to presently unserved rural areas with resources available for this purpose, independent of the number and location of land bases in those counties.

3. SECTION 707

CRIHB supports this amendment because it provides eligible California Indians who are not members of federally recognized tribes with some choice of health care providers without interfering with the right of federally recognized tribes to enter into 638 contracts for their members.

Under present IHS practice, if a tribe in a particular service area is awarded a 638 contract, it will be funded to serve not only its own members, but also other eligible Indians who are not affiliated with a recognized tribe but who reside in the same service area, without regard to the wishes of those unaffiliated Indians. CRIHB's position has always been that this practice violated federal law, 42 USC 2001(b), which requires the IHS to obtain "the consent of the Indian people served" before contracting for any services.

The § 707 provision is a compromise solution. It permits non-affiliated Indians to opt out of a contract if a majority of such Indians object to it, but it also expressly preserves "the right of any indian tribe to contract for health services on behalf of its own members." To interpet this provision as a "veto" of tribal contracts flies in the face of this unambiguous language as well as the language of the Congressional Conference Report, explaining the intent of this section, which states:

Under current law, the Secretary is authorized to contract for the provision of health services only with "the consent of the Indian people served". The Secretary has implemented this provision in contracts with tribes and tribal organizations, under the authority of the Indian Self-Determination Act, by obtaining resolutions of approval from the governing bodies of those tribes. In California, however, a substantial number of the Indian people served are not members of, or eligible for membership in, Indian tribes, and confusion exists concerning the extent of the Secretary's obligation to obtain consent in these circumstances. It is the purpose of this provision to eliminate this confusion by setting forth a concrete method for the Secretary to meet her obligation to obtain the consent of the non-affiliated Indians in California who receive health services through Indian Self-Determination Act contracts.

Finally, there are many other provisions of the bill which specifically strengthen and provide for equitable treatment of the tribally operated health programs in the determination and distribution of resources and services which we are pleased to see have remained intact. While these provisions will positively effect all IHS services in California (since we are all tribal contractors), we expect these to be of benefit to all tribes nationwide as the movement to assume tribal control of health services continues to grow. One amendment of special note is Section 712, "National Health Service Corps". During the past two years, we have witnessed the erosion of the NHSC positions assigned to the tribally operated programs in the state without replacement of positions or resources by the IHS. Any further loss of positions would pose a serious threat to the ability of several tribal contractors in California to maintain current levels of service. In one case, the United Indian Health Services, a CRIHB tribal subcontractor, the loss of their NHSC physicians would wipe out the entire medical delivery program which serves over 3000 eligible Indian people.

On behalf of the CRIHB member program and tribes, we wish to express our thanks to the members of the Committee and your excellent, dedicated staff for once again, moving forward expeditiously with this bill . . We are confident that together we will soon see the enactment of the Indian Health Care Improvement Act into law once again. Thank you.

Mr. **Taylor**. Thank you, both. It was very excellent testimony, and we thank you very much.

At this time, I think we are going to take a 5-minute break. I expect Senator Murkowski will be back around 2:15.

[Short recess taken.]

Mr. **Taylor**. We are going to resume the hearing at this time. Our next witness will be Francisca Hernandez of the Albuquerque Area Indian Health Board, accompanied by Ona Lara Porter.

I notice you have some charts with you. Have those been reduced and made a part of your prepared statement?

Ms. **Hernandez**. Yes, they have.[1]

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[1] See pp. 326-332.

STATEMENT OF FRANCISCA HERNANDEZ, EXECUTIVE DIRECTOR, ALBUQUERQUE AREA INDIAN HEALTH BOARD, ACCOMPANIED BY ONA LARA PORTER, DIRECTOR OF PLANNING, ALBUQUERQUE AREA INDIAN HEALTH BOARD

Ms. HERNANDEZ. We are representing the Albuquerque Area Indian Health Board. We thank you for this opportunity to present our perspective on S. 277. We have two testimonies that we have included for the record, but we will only address the issue of alcoholism prevention.

First of all, the charts are to speed up our testimony and make it as quickly as we can. All the information is in the record already.

Alcoholism, as we all know, is the number one problem in the Indian communities and definitely in the groups that we represent. It impacts every area of health, physical, mental, social, economic, political health, in all areas.

Most of the efforts so far have been geared to in-stage alcoholism, treating the person when all the resources have already collapsed in their lives. Their physical health, their mental health, and their economic and political strength have already weakened to the point that it is very difficult for them to return to a more productive life.

There are many programs that call themselves prevention, and their efforts are definitely essentially trying to do the best they can to solve the problem, but because there is no organized strategy and they are not taking the individual and the problem in a complete form in a very holistic way, they are not really touching the problem or they are barely touching it. Most of the preventive programs that exist are providing information on the problem of alcoholism, and information alone is not going to solve it, especially for young people. When you give information to young people, whether we are talking about alcoholism, other drugs, sex education, or any of these other problems that we are facing, what we are really doing is giving the young people new ways of doing actually what we want to prevent and it is not really stopping the problem at all, because we are not putting it into a framework of developing skills or clarifying values or clarifying for themselves ways of dealing with their lives more capably.

The other aspect that has been touched is recreation. Again, that is a way of distracting the young people for a little while from doing such things, whatever that is, whether it is drug taking or alcoholism or sexual activity or delinquency or any of these other problems we are facing. But we are not providing them with the skills and the guidance that they need to really change the way they are dealing with life.

Again, I want to emphasize that even though these approaches are narrow, they are well-intentioned, but we are not even beginning to touch the problem at its root.

The problems that we are finding among the youth—and I want to specify that although our experience is mostly with Indian people, we also have worked with non-Indian youth and the problems are very much the same for them, too. Most of the young people need intervention with professionals to stay out of trouble, whether those professionals are in mental health or teachers or are priests or counselors. They also lack skills, the basic skills, to deal with themselves as individuals.

First of all, there is a tremendous crisis of role modeling for young people. Second, they are not seeing themselves as significant contributors to the world in which they are living. Third, they do not see themselves as problems solvers, because the systems within which they are growing up do not allow them to become true problem solvers. They do not have any skills in terms of how to deal with themselves internally, intrapersonal skills. They do not have interpersonal skills, either, to deal with one another.

As a result of those things, they are perceiving themselves in such a poor way that their judgment is also impaired, thus not developing the judgmental skills that they need, not developing the situational skills they need. So, this is what the crises for these young people really are.

On top of that, they are growing up in alcoholic families in which the entire family is impacted. Again, I want to say that we are living in a society of addiction, addicted not only to alcohol but to many other things. These families are becoming dysfunctional as a result of the experiences that they are facing there.

If we do not begin to look at the problem in terms of that, of children growing up in dysfunctional families and thus developing behaviors that are dysfunctional, we are not going to touch the problem at all.

There is a very narrow understanding on the part of educators about what their role is in helping in the development of young people. They see their role as exclusively academic, teaching skills in math or reading or facts in history, and they are not really understanding that when kids spend most of their awake hours in the classroom that they are going to need more skills than just how to do math. Problem solving skills will include math, history, and also how to deal with life. They are not seeing themselves in that role at all.

Another thing is that there are other social pathologies that are occurring as a result of those lack of skills and as a result of dysfunctional families and as a result of a dysfunctional educational system. Those other pathologies are child abuse and neglect, sexual abuse, violence in the family, and so forth. If we do not look at the problem in a comprehensive way, we are not going to touch it. We are just going to waste our efforts and our money.

One of the things is that kids do need to learn the skills of life in schools and at home. The approach that we need to take is a strategy very similar to what people strategize to do during a war, because that is really what that is.

I want to let Ona bring the charts and we will explain, as briefly as we can, what our strategy is.

Ms. **Porter**. First of all, we are in a very unique position, working perhaps with some of the wealthiest tribes in the nation and also some of the poorest. In all of the cases, the thing that we see is that the way the organization of the tribe is is in this fashion shown on the bottom. It is around a quest for economic power, economic control.

However, one of the things that we have found is that it does not make any difference if our tribes are very well economically developed or very poorly economically developed. The same pathologies emerge at approximately the same rates in all of the tribes.

As a consequence, we have developed a new model for what we will put at the center of activity, and that is health or wellness. You can see then that economic development becomes a part of what is going on in the tribe but not the exclusive focus of what is going on in the tribe. How many things we are facing right now are a result of going down this road in terms of economic development and then having to come back years later and undo what we did there? So, if we put health and well-being at the center of all tribal decisionmaking and of all activity—and you can see also in the diagram above that we are talking about a true interaction between Government and the concept of wellness and justice and health and religion and so on. When we are pursuing purely the economic development approach, what we see is a one-way action in which decisions are made here, and everybody else has to adjust to those.

Ms. **Hernandez**. One of the things that I want to mention here is that this is very similar to the model that native Americans had originally, where economics is only part of the structure, not the center or the only main activity.

Ms. **Porter**. In our work, we have developed what we call a three-pronged approach to alcoholism, and we think that all of these things are required. Right now, there seems to be a dramatic shift toward prevention, but as Paquita mentioned, the prevention that most people are talking about is education and recreation. We believe neither of those is appropriate.

The other thing that prevention is commonly called is essentially finding kids who are young, who are in the disease but who are young, and they are our prevention target.

In our case, what we are talking about instead is that we maintain treatment, and we understand that treatment is dealing with serious alcohol problems and alcoholics.

Mr. **Taylor**. At this point, you are looking at the second chart in the order of your presentation?

Ms. **Porter**. Right.

Mr. **Taylor**. We need to have that in the record.

Ms. **Porter**. Thank you. I will mention that.

These individuals are very sick people, and this is a crisis-oriented approach. We believe that this is a very important distinction, that this crisis-oriented approach is a one-on-one approach. If we are successful in this approach, we are dealing with individual by individual problems.

Another prong of our attack is in the area of early identification and intervention. Here, we tried to identify why our people in our communities, seeing the problem of alcoholism in its early stages, ignored it. We, therefore, targeted in this area legal offenders, patients, drivers, students, and workers, and developed programs around those sites. These people are becoming sick, and an important factor to remember is that this also is a crisis oriented approach.

In primary prevention—we think the chart before indicated a wellness approach—we are working for something. We are working for community goals. These are working against a pathology. In this primary prevention approach that we take, children, parents, families, and all institutions in the community are targeted for reorganization and for strengthening. We believe strong people are well people, and that is a wellness orientation that we take.

Ms. Hernandez. When we are talking about primary prevention, again, we are working in an interconnected fashion. The teachers are included there. The principals are included there, the counselors, and the students. Everyone in the school system, everyone in the family system, not just mother and father, but the extended members of the family are also included in the effort, as well as the community as a whole. We are after the tribal leadership and all the decisionmaking in the community as part of the targeted population. So, when we are looking at prevention, we are not just saying that kid has a problem. We are saying all of the people have to work together to help these children become more capable.

Mr. Taylor. At this point, we are now on the third chart?

Ms. Porter. Yes, thank you.

Present programs are addressing areas of sick people and people who are becoming sick. Primarily, in this area, our treatment programs are focused on end-stage alcoholism.

In early identification and intervention, what we want to do is back up where we are dealing in the treatment modality with people. We believe that, as in any other disease, when we do that, our outcome will be more successful, so that is the early identification and intervention. Again, to distinguish that, in our communities, we work in both of these modes with people who are sick or becoming sick, but we work with the whole community in the wellness model.

Ms. Hernandez. I want to add, in terms of the early identification and intervention, there is treatment necessary for those individuals as well. Many people are looking at treatment only for the people who are very, very sick, but these people who are identified early with a problem need a specialized kind of treatment that is very different from the treatment that you give to someone who is in the end stages.

Another thing is that we are not saying that there is no need for treatment for those people who are in end stages. As long as people are sick, they need treatment, but what I am saying is we are backing up the treatment process as well. The things that we do for a 14-year-old who is addicted to sniffing a drug is going to be very different from the treatment we are going to give to somebody who is 50 years old who has been drinking for 25 years.

Ms. Porter. This is the fourth chart, and this demonstrates the interconnectedness of the approach that we are taking and that we propose for other communities who are similarly affected. Here, we are saying that it is necessary to have all three aspects and that the attack then becomes interconnected and multi-faceted. We have different approaches to meet different needs in different target populations. In this approach, it works together with all systems and people to bring health, strength, and productivity to the community.

Finally, in the fifth chart, we would like to demonstrate that we do not do anything to anybody or for anybody in this program. What we begin with in every community is the tribal needs and priorities. Around that we empower a group that we call a task force. The empowerment is essentially an orientation period in which the members of the task force are helped to understand the interconnected realities of their community which are creating the problem of alcoholism. Then, the task force works together with the community to create plans, to take action, and to develop programs which will then result in controlled change for a strong and secure tomorrow.

Ms. **Hernandez**. I want to give a quick example of one community in which this process is very advanced already. The priorities of the community, for instance, included the reorganization of their administrative system, the restructuring of their school system, the establishment of a judicial system they did not have, and an economic development plan. Those were the first four things they had to address, because they understood that until they had a system that they had created themselves, that they believed in, that they trusted in, that they ran themselves, they could not really help the people who had problems. So, that was the number one thing, and that was alcoholism prevention.

The next thing was to reorient their alcoholism treatment program to essentially deal with the early identified people and with young people, and also then begin to create an alcoholism prevention project specifically for kids in which all of those things that I mentioned before would be included.

Once again, I want to emphasize that the strategy is to get the tribal leadership involved in the problem and own the problem and educate themselves about it and how to deal with it, and then essentially have a community based representative group of decision-making entities or individuals who will be given the input and doing the planning and the implementation of the effort.

Finally, the training that takes place is first to develop an epidemiological picture of what their community looks like and then to take action through a problem solving approach to each one of those things but in an interconnected fashion. Essentially, we call it a socio-economic model with wellness at the center rather than economics.

Mr. **Taylor**. In the legislation, we have provision for the continued funding of existing alcohol programs as well as a new juvenile alcohol and drug prevention program. I certainly am impressed by your presentation and the charts. There is a great deal of sentiment in both the House and the Senate for this juvenile alcohol and drug abuse program.

Ms. **Hernandez**. Yes. Let me make one last remark. The concern we have for the legislation is that people may continue to look at it in a very narrow, specific way of dealing with the problem. I think we are not going to be able to be very effective if we look at it in a very narrow way.

In the Indian communities we have an advantage. The communities are small and they are circumscribed, so there are many changes that can occur in the schools and in the community that are generated by the people themselves if they have the support of the outside, especially the support of Congress.

Ms. **Porter**. But if we do not, in fact, improve the environment in which those adolescents are going to grow, merely targeting them in terms of their current addictions or preventing addictions is not going to be enough.

Ms. **Hernandez**. It is again going to be holding the victim responsible for the problems that they have.

Ms. **Zell**. I might add that Representative Bereuter and Representative Daschle in the House of Representatives have introduced a bill that deals especially and solely with juvenile alcoholism and drug abuse prevention. I would urge you to contact them and share your ideas with them. To the extent that those ideas may be incorporated in the bill as it passes through both Houses of Congress, I think you have a lot to add.

Thank you.

Ms. **Hernandez**. Thank you.

Ms. **Porter**. Thank you.

[The prepared statement follows. Testimony resumes on p. ?.]

PREPARED TESTIMONY OF THE ALBUQUERQUE AREA INDIAN HEALTH BOARD, PRESENTED BY FRANCISCA HERNANDEZ AND ONA LARA PORTER

On behalf of the membership of the Albuquerque Area Indian Health Board, I wish to express my appreciation to the committee for this opportunity to present our perspective regarding Senate Bill 277.

The concepts of treaty rights, sovereignty and international status, of tribes have been ridiculed by many non-Indian people. Yet the reality is that these are highly dignifying principles during a time when few people are willing to stand for any principles not directly connected to their or specific economic interests.

Governmental policy has consistently worked toward the extinction of treaty rights through a variety of types of legislation. It has been a losing battle for Indians in our effort at tireless resistance one generation after another to not succumb to complete anhilation or acculturation.

The policies of the federal government have violated the Indian concepts of ownership, leadership, dignity, self sufficiency. Whether intentionally or not the family structure was broken down and so were all other institutions. As these institutions deteriorated, as the source of food, shelter and economic survival were decimated, Indians came to be at the mercy of the invaders. Dependence became institutionalized through the reservation system.

The sense of powerlessness, the loss of status, of identity, obsolete skills, meaninglessness of the social relationships and cultural chaos have created pathological conditions that represent the possible destruction of our race. Self destructive behavior such as suicide, alcoholism, accidents, homicide and so onare only the tip of the iceberg.

Therefore, though it is accurate for Indians to blame whites for many of our problems, this is not enough. We must be able to work through this trauma and eventually emerge able to stand on our own and deal with today's reality effectively. In other words, though the whites forced those problems upon us at a point in history when we were powerless to make the events any different, today it is Indians who must deal with the problem.

However, without assistance we cannot alter the situation we are in. The epidemiology we face is so devastating that we cannot survive without help. It is in the areas of comprehensive physical, emotional, social and economic health and in education that we need assistance. The least the government can do is to provide such assistance in a way that fosters strength and interdependence.

It is ironic that we make great efforts to save the whooping crane and many other species (and we should) but at the same time we disregard the disappearance of an entire culture, race and way of life of our own species. Where are the principles that must rule the behavior of our leaders and of our country?

We are a sericusly disturbed society. Our pathology as a whole is not too different from that of the Indian. At the root of that pathology is our perception of the world and the value system by which we live as we are catapulted through time on the throws of unchecked technological change. It is time to begin a moral examination of our actions and beliefs in a more reflective and calmer way.

The present administration talks about reservation economies. But it has been the direction of the United States government that has placed us where we are today. For example, it is because of the Alaskan pipeline project that the Eskimos, Aleuts and Alaskan Indians entered into corporate organization of their lands. It was Congress who in 1971 established Native companies instead of Indian reservations. In 1991 the share and stock in those corporations can be sold. The multi-national giants are after that land and the resources because it is rich in oil, coal, gold, zinc and copper. If the Indians lose the land, their culture and way of life will be completely gone. Though the Native Alaskan represents 16% of the total population of that state, they represent 58% of Alaska's poor. What would it mean for them to lose the land? Does this mean we want to sacrifice the Native people for the rest of the population? What moral principle rules this behavior? Does the end justify the means? Is this not the same song with a modern beat that mainland tribes were destroyed by in the not too distant past?

The total Indian Health Service budget for Fiscal Year 1985 is about $850,000,000. This is less than we will spend in a day on defense in 1986. Yet the health status not only of Indians but of most minority Americans, a huge number of women and children and of many old people is in such disparity with that of the group in control that it's shameful by any moral principle that considers the dignity of human beings and the value of life on this earth. So who are we defending? Whose interests are being considered under our defense efforts and budgets?

The intent of democratic government is not to defend the interests of the already powerful, already healthy, already wealthy, but of those who are unable to challenge the power over them. This is why people empower the elected officials. Without this kind of perspective neither the Indians nor any other powerless group in this nation can be self determined. If we only represent the powerful, the powerless will be disenfranchized. Therefore, without the financing of health care and education, the tribes could never become self determined. Sick people cannot be in control of their lives. This is a very small price to pay for this country compared to the price Indians have paid. If we truly believe in justice, what other alternative is there?

Most tribes today are in the process of socio-economic development. It must be emphasized that this development has to be social and not just economic if it is indeed the interest of Congress to help tribes become capable of self government. Without the support of the government these capabilities cannot be developed. From complete interdependence with our environment Indian people were forced into complete dependence on another group of people. To bring them back to interdependence with the rest of society requires aid from the ones who have power. A very first step is to raise their health status to that of the rest of the nation's population.

Our country is going through an economic crisis. If the crisis was being carried equally by everyone we wouldn't have anything to complain about. But it is not. Thus, if we want to defend our country, let us start defending all of its people and not just the power holders.

Turning our attention to the specifics, Indian people need the health facilities, the health care, the management assistance spelled out in Senate Bill 277. We need the direct services that allow for intervention with the pathologies we face; we need the preventive services that will make possible the elimination or reduction of these pathologies; and we need the health promotion services that will strengthen what is already healthy in our lives. Indians live in the cities as well as the rural areas just like the rest of the people do in this country. Thus 12 million dollars to care for the health of 50% of all Indians is nothing compared to the trillions that have been taken away from us to benefit this nation.

As the Indian people become well, self determined and powerful, we will want economic and social emancipation from the government. No one wants to be a ward of anyone else. We are only asking for what we need and what is our due.

This is why specific issues such as a separate line item for indirect cost to cover the administration of contracts under Public Law 93-638 are so crucially interconnected to the principle of socio-economic emancipation. Important as well is the authority to collect third party payments.

As consumers of health care services structured in an alien world, Indian people need a consumer representative group that can assist them in their local health policy development and health services implementation.

Again, we like to talk about human rights, sovereignty, freedom and international status but we only think of those concepts for those who have the power of the gun and of the dollar. It would be a better world for all of us if we thought of these concepts in terms of principles for human dignity, peace and sharing and mandated that the laws, programs, policies and budgets of our nation uphold those principles.

PREPARED STATEMENT OF THE ALBUQUERQUE AREA INDIAN HEALTH BOARD, PRESENTED BY FRANCISCA HERNANDEZ AND ONA LARA PORTER

On behalf of the membership of the Albuquerque Area Indian Health Board, I wish to express my appreciation to the committee for this opportunity to present our perspective regarding Senate Bill 277, and more specifically the provisions for alcoholism prevention.

Although alcoholism and other substance abuse is recognized as the number one health and social problem among Indian people, most of the effort to address the problem has gone to treatment of those who have become seriously ill. Many programs have called themselves preventive efforts when in reality no organized strategy has been considered or put into effect that addresses the need to change the circumstances of people. Many prevention programs have limited their activities to providing information, which has proven to increase the usage rather than diminish or prevent it; or they have chosen recreation which only distracts the young people for a short period of time without any self directed change.

In both Indian and non-Indian communities, our involvement with young people over the last 10 years has confirmed the outcomes of National research which has found the vulnerability to addictions by young people related to the following:

The majority of today's youth are in need of outside professional intervention in their lives to try to live without getting into serious difficulties, whether in school or home, with alcohol, suicide, depression, early pregnancy or delinquent behavior.

The basic problem the youth are confronting is that they have not learned enough skills for living as capable individuals or so they could function at successful levels at school, home, in the community, at work or in society in general.

Families impacted by alcoholism or any kind of addiction are unable to give children these skills. The children are learning not only to drink but they are learning alcoholic behavior as well.

Schools do not see themselves as responsible for doing anything for children except teaching academic subjects and skills. This narrow understanding by educators is contributing to the huge rate of placements in special education, truancy, dropout and failure rates. Even children who make it through school are unprepared to get jobs, go on to other educational opportunities, or behave and accept the responsibilities of adult life.

Alcoholism, family violence, child abuse and neglect, divorce, desertion, suicide are reaching disastrous proportions among families also. Thus, many parents do not have the capabilities to know how to give guidance to their children or how to give them those skills that will help them throughout life or even to cope with immediate behavioral problems.

The reality is that we have the means within families and schools to prepare our children in much better ways that we are presently doing. But we need to make the plan for it and then follow the plan. We need to understand that children are born dependent, but with the potential to become interdependent. In order for that potential to be developed, their bodies, their souls and their minds need to grow. But that is not an act of magic. This growth requires experiences provided at home and in school and in society at large which will help them learn the skills for interdependent living.

When we see alcoholism as a prominent factor in family violence, abuse and neglect, we know that these children cannot have the experiences necessary for healthy growth. Though alcoholism is the most apparent problem, there are also the other problems mentioned above and all of them must be addressed simultaneously because one will lead to the other sooner or later. For example, the child facing a violent situation at home and failing in school is likely to attempt to commit suicide, get drunk, be full of anger, express themselves through delinquent behavior, etc.

Why have prevention programs not worked?

Our society in general and communities and programs in specific have concentrated their efforts on sending alcoholic people to treatment after they are approaching end stages of the disease. This is the exclusively medical or curative model.

Efforts have been concentrated on the alcoholic and not on treating the entire family affected by the problem or dealing with the community or societal issues that have given rise to the problem.

The people involved in prevention programs either do not have the professional qualifications to effectively do the job or do not understand the problem at a fundamental level and therefore, do not know how to make the plan attack it.

For many people there is the belief that all children will experiment with alcohol and that many of these will become regular users by the time they are in the seventh or eighth grade.

The schools see themselves as places to teach isolated skills in academics, when in reality you cannot teach someone when separating his/her personal growth from academics. This practice in our schools is a tacit admission that what happens in the classroom is naive, impractical, indifferent to the facts of life and not so useful as "worldly" experience. The classrooms of our society are not the place where rigorous and able minds are formed and where sensitive caring persons are developed. They do not provide a humanizing experience for children.

There is a need to change attitudes toward prevention. Right now the perceptions are that if we keep the children occupied, they won't get into trouble. Therefore, recreation is emphasized without developing any skills that would help them become more responsible and accountable and everything is offered already digested thus preventing critical thinking minds from developing. Adults are so insecure themselves that they fluctuate from permissiveness to punishment with very little space for young people to develop the skills necessary to deal with situations, exercise judgment, and to feel that they are true contributors to the world in which they live.

In our approach to the prevention of alcoholism in specific and addictions and other social pathologies in general we look at the entire socio-economic and political structure of the community and how it fits into the larger society. Then we plan our attack in an interconnected and multiphasic fashion, recognizing that we need different strategies to meet different needs and different target populations. We work together with all community systems and people to bring health, strength and productivity to the entire community. We call this the three pronged approach which for the purpose of clarify we separate into Primary Prevention, Early Identification and Intervention and Treatment.

Our primary prevention approach includes children, parents, families, schools, teachers, youth organizations, tribal leadership and community planning for economic or social purposes. This is a wellness model. (See charts No. 1, 2, and 4.)

The Early Identification and Intervention aspect includes legal offenders, DWI offenders, students who have any kind of problem, workers with problems related to addictions which interfere with their work performance, patients, doctors, employers, teachers, counselors, school principals and the judicial system. The people in this category are individuals who are becoming sick and those around them who are their support network.

In the treatment category we have people who are very sick. They are either alcoholics or have serious alcohol problems.

Thus, our primary prevention is a wellness oriented effort while the other two prongs are crisis oriented. They all have to be addressed simultaneously because it is useless to work with a child that we are sending back to an alcoholic parent or to a racist teacher. (See charts no. 1, 2, and 4.)

Our model is an effort to redirect our present system of having economic power at the center of all our activities to one where the wellness of people and the community is the center and criteria by which all decisions are made.

Since we base our society in the economic structure, all other institutions must adapt to the economic changes. This includes the religious institutions. Here is where the emotional and spiritual justifications for new accommodations must be made. Here also, is where our code of ethics is reinforced. Schools must also adapt because they are the training center for new producers and consumers. The family also must accommodate itself because they pass on the values of the society, the rules and roles of the systems, the reinforcement of the ethical perspectives and the legitimization of the legal structures. And our leadership follows the economic trends and mandates accommodating itself to the responses received from the market places. (See chart no. 4.)

All of these structures and institutions with their values and perspectives dictate our behavior as individuals and as a community or society.

When we change that around and put wellness at the center of all activity, our choices and decisions change dramatically. When the family values emphasize physical and emotional health, disciplined and critically thinking minds, and responsible and accountable citizens the picture begins to change. When the health system looks at our problems in a wholistic and epidemiological fashion; when we treat the person as a total system and offer services in an interconnected manner, people begin to be in control of their own well-being. When our churches begin to develop an approach to the clarification of values that affirms the life and dignity of all people; when they offer a place for reflection and dialogue, a place for clarity, affirmation, permanence and stability, communication and peace, people will begin to feel more powerful, less alien and less anomic. When our leadership begins to fill the role of behavioral model that reflects principles of life affirmation, peace, justice and humaneness, people will begin to follow their steps and to lead healthier lives for themselves. Only then will we have true justice and socio-economic development for all people.

The specific way in which we presently plan our work in the Indian communities we represent is by putting at the center the tribal needs and priorities as identified by our team and the community people. Our first target is the tribal leadership. They must understand and support the concepts and approach. They must select a group of strong, capable individuals representing all sectors of the community to form a task force. For a period of time this group is trained to understand the socio-economic conditions of all people with special emphasis on children, the epidemiological picture of the communities and of alcoholism specifically and to understand their role as change agents. We work toward making values clarification statements that include what will be promoted and what they will be looking for in the next five, ten and twenty years and plan to achieve. We help then conceive what the ideal is, recognize clearly what the reality around them is and through dialogue help them identify the root causes of the problems and how to search for alternative system/change solutions. (See charts 5, 6 and 7.)

We follow this with a planning period where problems, goals, strategies and detailed implementation plans are outlined. These are then presented and discussed with the tribal leadership for approval and support. And we begin the implementation activity.

In one of our communities we have gone through the following:

1. Reorganization of the entire administrative system of the community.
2. Restructure of the community's political system where a balance between traditional and modern structures was achieved bringing together all groups.
3. We are in the process of establishing a judicial system that incorporates the laws of the United States and the traditional values of the communities in a way that serves the specific needs of the people.
4. We are in the process of reorganizing their school including curriculum, teachers and so on.
5. We have put together a comprehensive alcoholism prevention strategy that addresses:

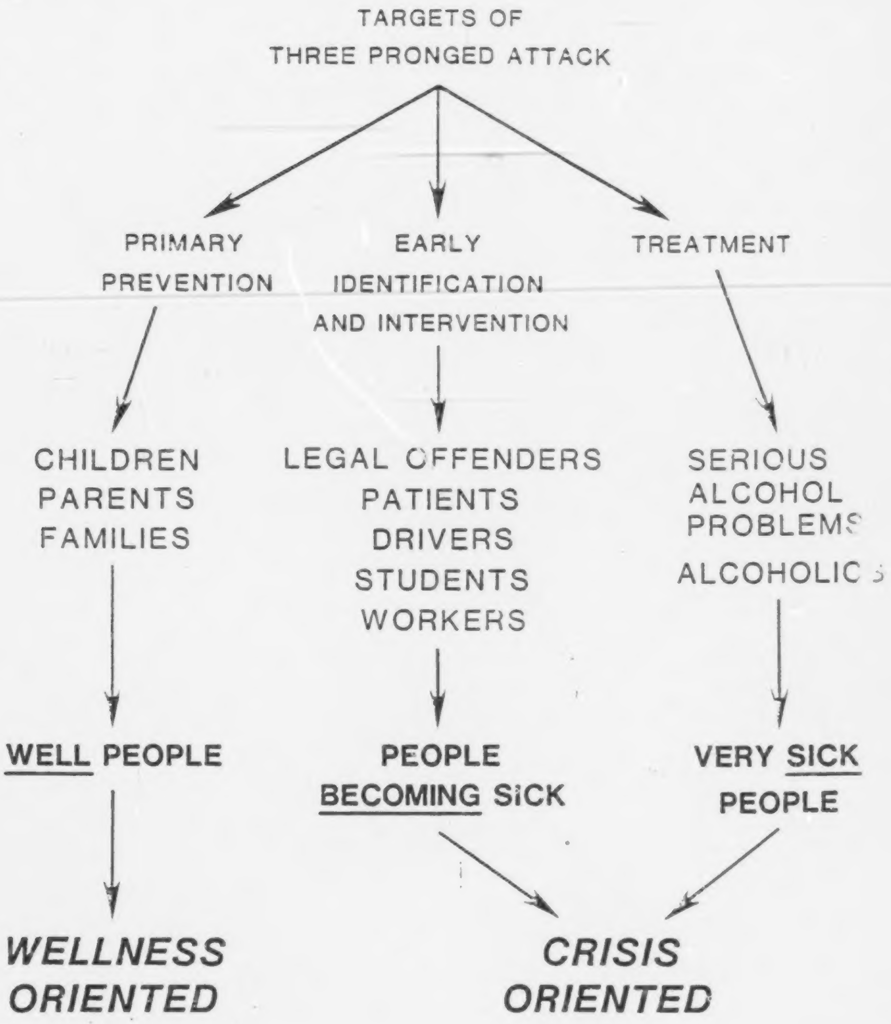
Developing capable parents; Teacher training in the incorporation of human development skills into the academic curriculum; Academic readiness for children; A center for youth activities that includes democratic problem solving experiences for children 6–14, assistance for homework, group and individual counseling, and a recreational summer program where children under the direction of adults plan, raise the money for and manage during the year. The center is open from 3:00 P.M. to 8:00 P.M., 6 days a week; An advocacy network for elementary school children and a mentoring system for youngsters in the middle and high school; An adult literacy plan which is intended to raise the functional skills of all community members to a sixth grade level.

6. We have created an economic development plan which is intended to develop skills and jobs in the community which are in harmony with the land and the people which meet their fundamental needs. The plan will not promote dependency, threaten water, air or land quality or undermine their strength as a race or culture.
7. We have reoriented the alcoholism treatment toward early identification and intervention where a network of the community physician, employers, religious leaders, community leadership and family will all come together to insure the sick person goes to treatment and follows after care assistance to complete recovery. There is no way that that person can remain in the community without help. A family therapy model has been incorporated to assist the rest of the family in its recovery from the traumas suffered as a result of living with a dysfunctional person. For the end stage alcoholics, we have identified resources that can offer humane care and which frees the family from any further trauma.

The problems affecting children and families in our society are numerous. Addictions take many forms: alcoholism is only one. Until we find the common denominator of all these problems and go after it, we will be fooling ourselves with paliatives. Because all of these problems are interconnected, we need to have solutions that are also interconnected. Because it is an issue of mental, physical, and social health we must make the wellness of the people our primary goal.

Because these pathologies include not only addiction, but sex related crimes, personal and social dysfunctions, physical, mental and sexual abuse of one another we are talking about a tremendously high number of people. Dollars alone will not improve the situation. We must have the courage to go after systemic changes. As long as economics sits in the center of all our efforts making the acquisition of dollars our main and only goal, we won't get people well. We must have the dollars as a means, but the goal must be the well-being of people.

We ask for your approval of Senate Bill 277 and its provisions for alcoholism prevention as a first step toward effectively addressing the problems we face in our communities.


TARGETS OF
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STUDENTS
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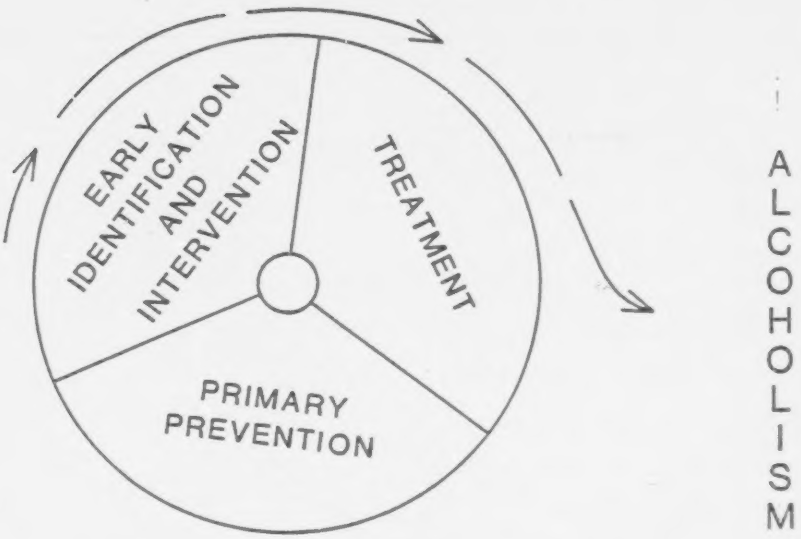
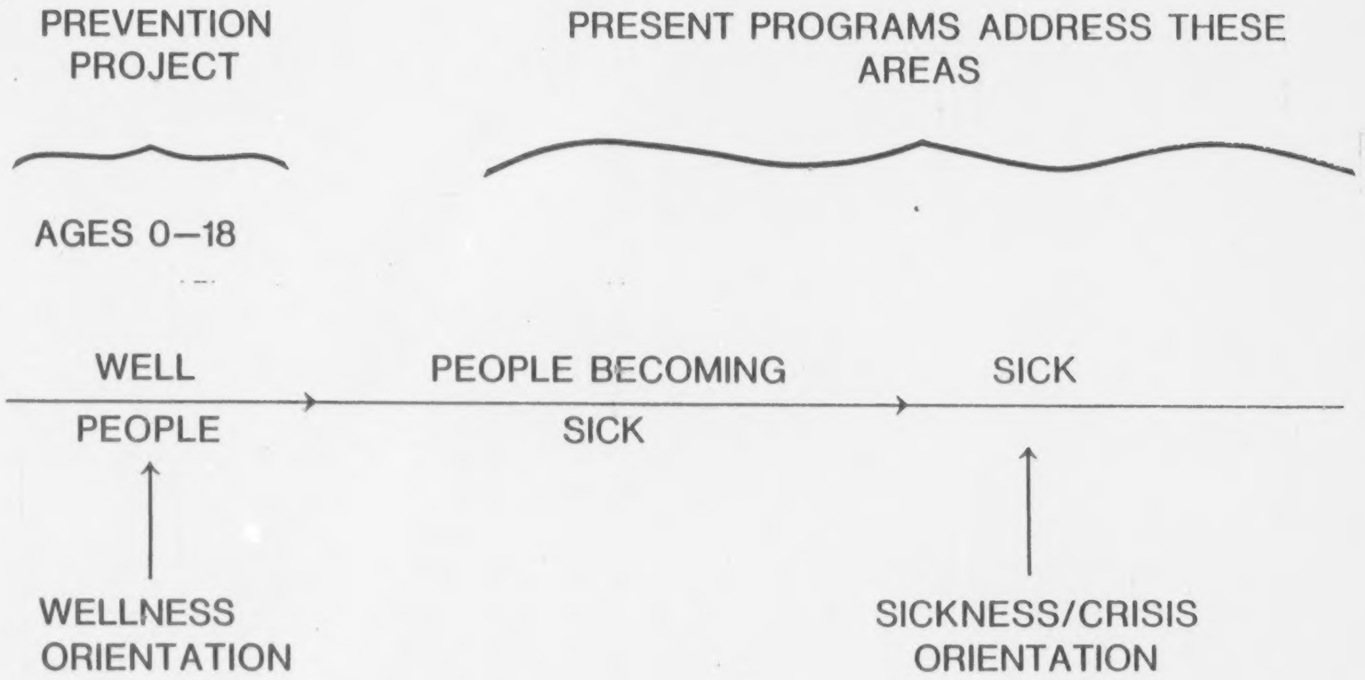
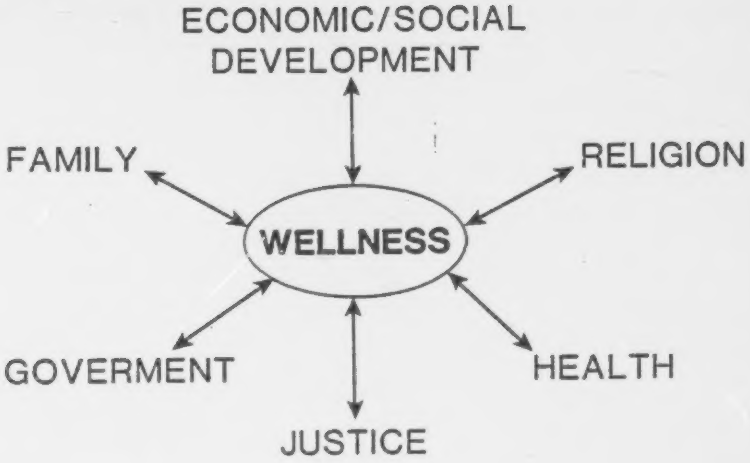

EARLY IDENTIFICATION AND INTERVENTION
TREATMENT
PRIMARY PREVENTION
ALCOHOLISM

ATTACK:

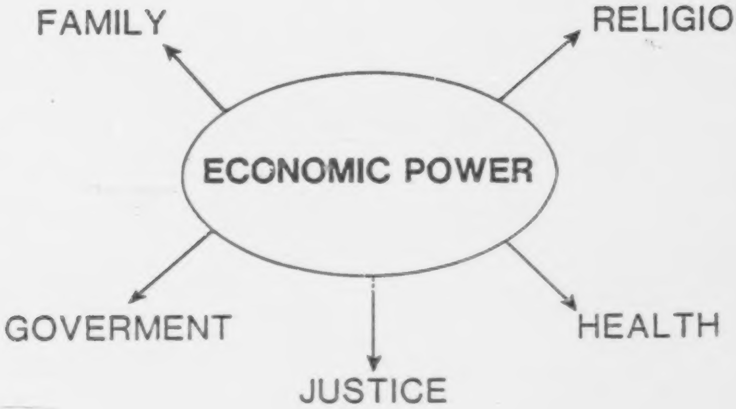
- IS INTERCONNECTED AND MULTIFACETED
- HAS DIFFERENT APPROACHES TO MEET DIFFERENT NEEDS/DIFFERENT TARGET POPULATIONS
- WORKS TOGETHER WITH ALL SYSTEMS AND PEOPLE TO BRING HEALTH, STRENGTH AND PRODUCTIVITY TO THE COMMUNITY

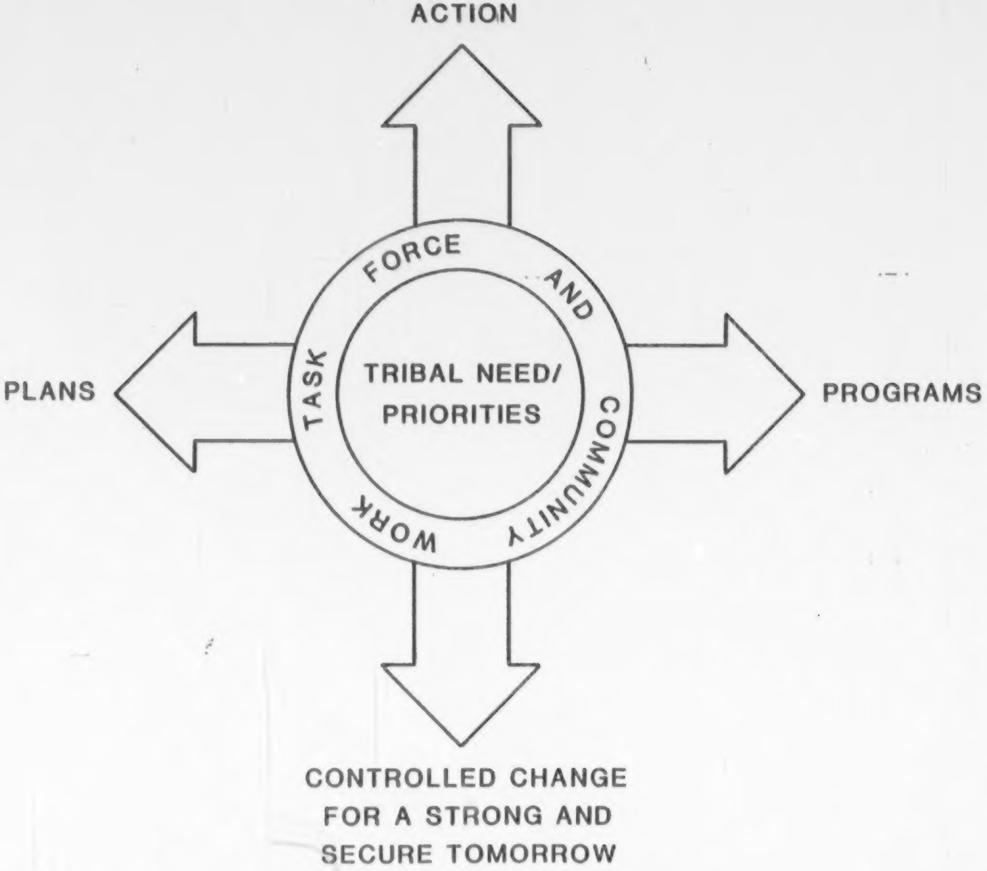

PREVENTION PROJECT
PRESENT PROGRAMS ADDRESS THESE AREAS
AGES 0–18
WELL PEOPLE
PEOPLE BECOMING SICK
SICK
WELLNESS ORIENTATION
SICKNESS/CRISIS ORIENTATION

● PROPOSED SYSTEM


ECONOMIC/SOCIAL DEVELOPMENT
FAMILY
RELIGION
WELLNESS
GOVERMENT
HEALTH
JUSTICE

▲ CURRENT SYSTEMS


FAMILY
RELIGION
ECONOMIC POWER
GOVERMENT
HEALTH
JUSTICE


ACTION
FORCE
AND
TASK
TRIBAL NEED/
PRIORITIES
COMMUNITY
WORK
PLANS
PROGRAMS
CONTROLLED CHANGE
FOR A STRONG AND
SECURE TOMORROW

THE IDEAL
VS.
THE REAL

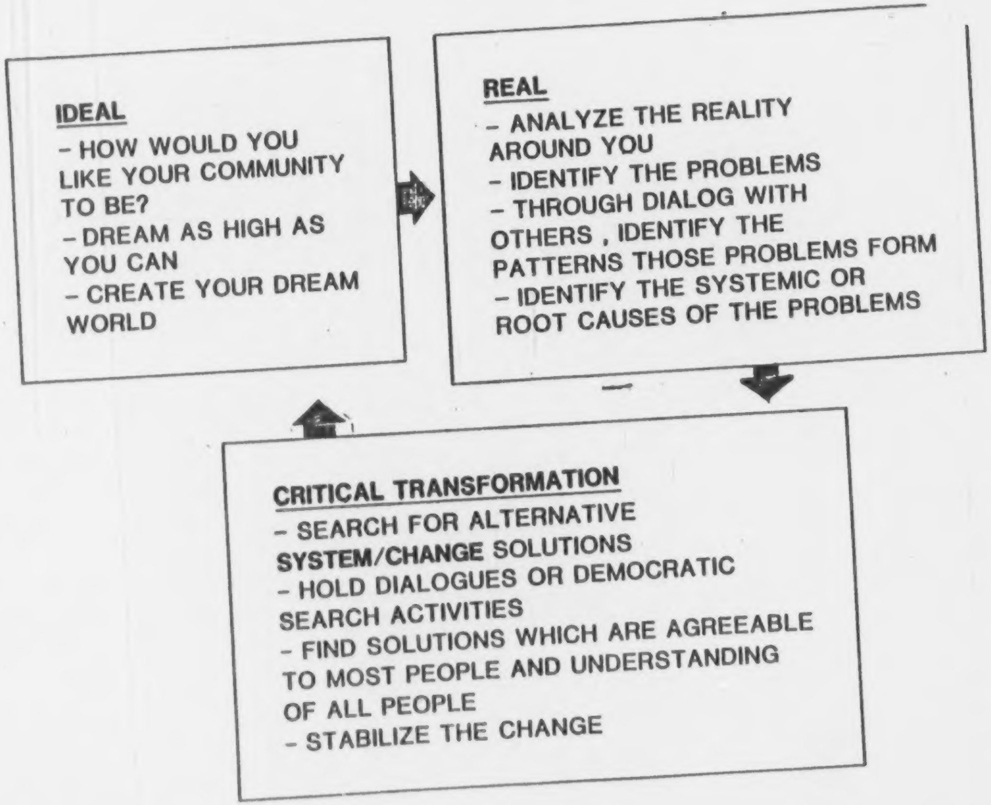
● ← **IDEAL** →

DIGNITY AND STRENGTH
KNOWLEDGE AND WELLNESS
MEANINGFUL WORK FOR ALL PEOPLE
PRODUCTIVITY AND SELF RESPECT

▲ ← **REAL** →

ALCOHOLISM & CHEMICAL ABUSE / DEPENDENCY
CRIME AND DELINQUENCY
VIOLENCE AND PERSONAL ABUSE & NEGLECT
PHYSICAL AND MENTAL DISORIENTATION
ABUSE AND NEGLECT OF OTHERS
LOW EDUCATIONAL ACHIEVEMENT
LACK OF PERSONAL AND SOCIAL
PERFORMANCE AND PRODUCTIVITY
LOW SELF-ESTEEM
CULTURAL DISINTEGRATION
OPPRESSION AND POWERLESSNESS

- DEFINING AND ACHIEVING THE IDEAL



IDEAL
- HOW WOULD YOU LIKE YOUR COMMUNITY TO BE?
- DREAM AS HIGH AS YOU CAN
- CREATE YOUR DREAM WORLD

REAL
- ANALYZE THE REALITY AROUND YOU
- IDENTIFY THE PROBLEMS
- THROUGH DIALOG WITH OTHERS , IDENTIFY THE PATTERNS THOSE PROBLEMS FORM
- IDENTIFY THE SYSTEMIC OR ROOT CAUSES OF THE PROBLEMS

CRITICAL TRANSFORMATION
- SEARCH FOR ALTERNATIVE **SYSTEM/CHANGE** SOLUTIONS
- HOLD DIALOGUES OR DEMOCRATIC SEARCH ACTIVITIES
- FIND SOLUTIONS WHICH ARE AGREEABLE TO MOST PEOPLE AND UNDERSTANDING OF ALL PEOPLE
- STABILIZE THE CHANGE

Mr. Taylor. I am going to skip a little on our witness list. I would like to call next Bob Rich, director of the Seneca Nation Health Department in Salamanca, NY.

STATEMENT OF ROBERT RICH, ASSISTANT DIRECTOR, SENECA NATION HEALTH DEPARTMENT

Mr. Rich. Thank you. First I would like to clarify that I am the assistant director of the Department. Rae Snyder is the Director.

I would like to thank the chairman and committee members for the opportunity to testify on the subject of information systems and the Indian Health Service, and specifically on related provisions in S. 277.

My name is Robert Rich, and this testimony is being presented on behalf of the Seneca Nation Health Department which was established in 1976 under the Indian Self-Determination Act.

The Department operates a comprehensive health program serving over 7,000 Indians in a five-county area, from Buffalo, New York into northwestern Pennsylvania.

We have been actively pursuing systems automation at the Seneca Nation for over 10 years, and are currently implementing an automated medical record system called COSTAR. COSTAR is in the public domain, and when linked with our existing financial reporting and contract health care system, it will be the tribal equivalent of what is now being called a resource and patient management system, or RPMS, for the Indian Health Service.

To begin with, it seems significant that the Indian Health Service is being compelled by law to address an area that is commonly regarded as an integral part of contemporary management. Indeed, since IHS already has over 60 data processing systems in operation, it would seem unnecessary to provide such guidance. In spite of these 60-odd systems, however, it is well known that the agency does not possess a management information system.

The reasons for this apparent inconsistency are undoubtedly many. They mostly seem to center around problems associated with development staggered over time in the midst of a very rapidly changing technology. The Indian Health Service was, in fact, a pioneer in the use of automation in health care. In particular, conception, design, and implementation of IHS's Health Information System in the early 1970's is of historic significance in the field. The agency should not be judged too harshly for undertaking major endeavors with still formative tools.

The agency right now, in fact, is engaging itself in a massive overhaul of its information systems toward the same end products as specified in the bill under consideration. Patterned after the Veterans' Administration model of shared development, IHS is pursuing a MUMPS-based file manager compatible system that will place the bulk of the computing power and information base at the point of patient care. Responsive mechanisms to assure timely access to aggregate data at other levels of administration are also being addressed.

If implemented as conceived, the current approach by IHS should fulfill the expectations of the bill, and as a tribal program with experience in health systems automation, we generally support the current initiative.

A number of factors, however, both from within the agency and from external sources, present serious obstacles to a smooth transition from the current situation to a unified information base in IHS. The ones itemized here are, of course, in addition to inherent resistances to change that exist in every institution.

The IHS provides health care in hundreds of different locations, serving hundreds of separate populations, each with its own unique culture. This reality has caused the agency to develop with relative independence at the area level which, while appropriate in many ways, is difficult to function with in implementing a shared systems approach where standardization is essential.

This is a particularly acute problem in systems planning and implementation, because there is no distinct budget line item for information systems. Financial assistance for systems development is residual, and each area determines how much can be spared from their hospital and health clinic accounts. This situation needs to be addressed by specific line itemization of information systems, both for accountability of the effort and the stability of support that is required for a sustained agency-wide initiative.

IHS also lacks a key management decisionmaking capability, hardware procurement. Equipment procurement clearances at levels above the IHS result in extensive turnaround times which are particularly frustrating when spending advisements are not made until very late in the fiscal year. We think that the management principle of authority equal to responsibility is at issue here, and changes need to be made. Perhaps agency level positioning of IHS in the Department would have the needed effect.

The Indian Health Service faces as well a formidable challenge in reorienting its management and administrative systems for an integrated cost accounting system. Since budget management does not currently occur at the the service unit level, a large gap exists in implementing a functioning system to control costs at their origin. Budget development, maintenance, and control will be critical training areas for IHS over the next few years.

At the upper levels of IHS, it appears that expertise in all aspects of information systems needs to be cultivated. Upper management seems somewhat naive about the time and resource requirements of information systems development and unsure about giving information systems a prominent role in the hierarchy. The ability of individual areas to override agency-wide systems planning and make discretionary funding decisions highlights an underlying continuity and coordination problem. The critical need for decisionmaking authority by the information systems effort needs to be recognized in IHS and appropriate delegations made.

From a tribal perspective, certain concerns exist regarding IHS's approach. They are: No. 1, in spite of numerous areas of common information needs, very little tribal involvement is being accommodated; No. 2, the bulk of the resources that are being devoted to the effort are for direct IHS operations, not tribally contracted programs; and No. 3, no progress has been made in negotiating a standard set of data to be reported by tribal programs.

These difficulties will fragment information systems between IHS and the tribes and will compromise ultimate utility.

Tribes around the country are becoming very active in this area and have important perspectives and expertise to offer. A genuine effort needs to be made to assure that tribal information system needs are supported and are recognized as being crucial to Indian health care as the agency's. In that regard, it would be helpful if a portion of all resources called for in the bill could be earmarked for tribal systems development.

As earlier stated, we generally support IHS's current RPMS initiative and believe that, with active tribal participation, and with certain key obstacles removed, the agency can meet the worthwhile information systems objectives stated in S. 277.

Thank you again for the opportunity to present the views of the Seneca Nation Health Department on this crucial piece of legislation. I would be happy to answer any questions you might have.

Mr. **Taylor**. Mr. Rich, I do not think we have any questions, but I would like to comment that we consider the establishment of this management information system to be a very important part of the legislation that is before us. I do not believe we have any questions, but thank you very much for your testimony.

Mr. **Rich**. Thank you.

Mr. **Taylor**. Next, I would like to call William Williams, president and chairman of the board, Tanana Chiefs Conference of Fairbanks, AL. He is accompanied by David Mather, the director of health services.

Senator **Murkowski** [acting chairman]. Thank you, Pete.

Welcome to the Select Committee on Indian Affairs, gentlemen. I welcome you, Don, and you, Spud, to the full committee.

I have a short opening statement, and I have had an opportunity to review your statement. I would appreciate, of course, your highlighting it and making any comments that you would care to make.

We, of course, are aware of the status of the bill during the 98th session of Congress. Although it was a good bill, it was vetoed for reasons that were nongermane to the particular interests of Alaska and Alaska's native people.

I would like to emphasize that the extension of the Indian Health Care Improvement Act is essential to all American Indians and particularly Alaska's native community. Many of the provisions of the bill directly address the health needs of Alaska's native community.

Section 716 requires the Secretary to complete a program which is now in place to eradicate hepatitis B. I have been very active in urging that the appropriate moneys be funneled into that program because, obviously, it is of high identity and something that can be resolved with technology that is now available. I was pleased to note that there is a significant amount of funding in the administration's budget for hepatitis B. I am told it is $2.7 million which should substantially reduce the requirement for the State of Alaska to provide matching funds or participation in the amount that they were previously requested to do and which they saw fit to do.

The legislation also requires the Secretary of Health and Human Services to begin to develop and implement a plan to reduce the rate of Indian infant mortality. Mortality among Alaska native infants is much higher than the average by several percentage points.

Of course, the incidence of alcoholism in Alaska is far too high. I particularly support the portion that addresses the establishment of an office of alcohol and drug abuse within the Indian Health Service.

Senator Stevens and I offered amendments last year to the bill. Our amendments set up a demonstration program which would allow tribal contractors, such as yourself, which operate through your Tanana Chiefs Indian Health Facility, to directly bill for, and retain 100 percent of, the Medicaid-Medicare reimbursements that you collect. This program will allow the Congress to evaluate whether the tribal contractors are able to increase collections and, at the same time, carry out the intent of the public law by giving you, as a contractor, complete control of the financial management of the facilities.

I believe that prompt passage of this bill will be a confirmation that the Government intends to fulfill its repsonsibilities and do a better job of providing health care services to American Indians and, of course, particularly Alaska Natives.

I believe that you would like to highlight your testimony which will be entered into the record in its entirety as if read. You may proceed and I would welcome your general observations of any comments that I have made.

STATEMENT OF WILLIAM C. WILLIAMS, PRESIDENT AND CHAIRMAN OF THE BOARD, TANANA CHIEFS CONFERENCE, ACCOMPANIED BY DAVID MATHER, DIRECTOR OF HEALTH SERVICES, TANANA CHIEFS CONFERENCE

Mr. WILLIAMS. Thank you, Senator. I appreciate the invitation to come back and testify at this time.

The Tanana Chiefs Conference represents 43 villages or tribes in the interior of Alaska. We are specifically interested in section 405 of the bill which deals with pilot projects in collections of Medicare and Medicaid and other third party payments, and so forth.

We have been in the process of assuming control of the health delivery programs in our region for quite awhile. We have come to the position now of total control and total assumption of all of those services in our region.

In that planning process, we have extensively upgraded the IHS systems as far as billings, collections, and recordkeeping, and we bought extensive hardware and software. We have invested about $250,000 in those systems and in that hardware.

We feel that we will be able to vastly increase collections by better management at a local level, right there at the clinic, doing it ourselves for ourselves, but we have to have the incentive to do that. The incentive to do that is that we get to keep the money we collect.

The bill itself speaks to improving the Indian health situation by improving the health delivery systems for our people. We have included in our formal testimony an underlined section where we want to protect those dollars from any further encroachment by the Government by allowing us to use the money for specific improvements and additions to the health delivery systems.

Everybody recognizes that the Indian Health Service does not have adequate funds. Everybody recognizes that the Indian Health Service does not have an adequate service delivery system. Everybody recognizes that the status of Indian health is very poor across the Nation.

We would like to demonstrate that local control, local management, local decisionmaking, local policymaking, by our people can better the system. I think one of the weaknesses of the IHS collection systems is that they cannot see the immediate returns and the immediate rewards by being able to utilize those dollars for increased benefits to the service population. So, we would like to be able to develop our systems, utilize our systems to the fullest to prove that it can be improved, that we can do a better job. With the passage of this bill, we would like to demonstrate that.

I have my health director with me, Dave Mather, and he can go through some of the other changes that we would like to speak to in the bill as well as give you fuller details and a little more information on the systems and how we would like to see them operate.

Senator **Murkowski**. Thank you very much, Mr. Williams.

I apologize for kind of the hit and miss schedule you have been on. My schedule is very similar. I think I have three meetings at 2 o'clock and it is now 2:45, and this afternoon has gone the way many afternoons around here go, but I am glad that you were able to accommodate my schedule. I do appreciate the opportunity to visit with you over these important questions.

I understand the Assistant Secretary for Health has approved the expenditure of about $2 million in planning and evaluation funds. This is a question that I was going to ask Dr. Rhoades, but in view of the role that you play in interacting generally with health matters, I will ask you. How do you see the question of the Alaskan Native medical hospital replacement, which has been approved for planning money in Alaska, interacting with your health services that you provide through the Tanana Chiefs Conference? Is that a duplicative role or is it single and unique inasmuch as the hospital will provide inhouse service as opposed to outpatient care, which is not necessarily what you provide directly but you do it indirectly through the private sector? In view of the fact that there is an approved expenditure of $2 million in planning for this new facility, I am curious to know how it interacts with your programs and whether you see any potential conflicts or not.

Mr. **Mather**. We still refer complex cases that will require extensive resources to the Alaska Native Medical Center, and its replacement is critical also to the Tanana Chiefs Conference. The Alaska Native community in general has been trying for 2 years to get Undersecretary Forbush to release that $2 million which, I believe, was appropriated in 1984, and they have made some unsolicited proposals to the Indian Health Service to try to expedite the design and construction and building of that facility.

Senator **Murkowski**. Do you have, as a potential user of that facility, any input in their planning process?

Mr. **Mather**. We have had very little input to date.

Senator MURKOWSKI. Do you intend to pursue the opportunity, if presented? It would seem to me that with your reputation as one of the major health care capabilities within the interior, and a potential user of that facility, that you would be inclined to provide them with some worthwhile suggestions on load factors and so forth. I assume it is of some concern to the community of Fairbanks because they have certain facilities in their planning as well. I am not implying a lecture, by any means, but it would seem to me that, with the $2 million in planning, they should take advantage of your input. I would urge that that take place if it is appropriate.

Mr. WILLIAMS. Senator, there is a statewide health board in Alaska. That health board is proposing to design the hospital for IHS. They are developing a proposal to do the designing and the feasibility study of the facility itself.

Mr. MATHER. Part of that proposal is to hold statewide hearings in the Alaska Native communities on what the central role of that hospital should be and where it should be located in Anchorage. There is some discussion on site selection, et cetera. So, there is a proposal to have hearings statewide.

Senator MURKOWSKI. I think it is appropriate that, as a major user, that they might consult you since the planning money is going to become [illegible]eality.

Mr. WILLIAMS[illegible]e fully intend to have our voice heard.

Senator MURKOWSKI. Good.

You have recommended in your testimony that the demonstration project be extended for 5 years and you request, on the basis of expenditure of resources, the need for increased public information on the utilization of this. I am wondering, can you explain a little more, for the record, what kind of expenditures you would anticipate and what constitutes sustained and significant public information of the type that you intend to disseminate?

Mr. MATHER. What we requested is that the demonstration project be expanded from a 2-year to a 5-year project; that the demonstration project be expanded to 5 years of actual billing experience. The reason we requested that expansion is because if we are truly going to demonstrate what the capabilities of native organizations are, we feel there needs to be time to allow the native corporations to develop mature billing systems to actively pursue an outreach program that will encourage people to utilize their alternate revenues, both private insurance as well as Medicaid and Medicare. Also, so that we can demonstrate some benefit to our constituents which will in turn encourage them to maximize their eligibility for Medicaid and to notify us when other third party resources are available.

We have 14,000 records, all of which we have to update with adequate insurance billing information. This is a time consuming and resource intensive process.

Senator MURKOWSKI. I am interested in that last comment. You say, insurance and where you can bill. I happen to be chairman of the Veterans' Affairs Committee, and we have the largest private or semiprivate health care facility, certainly the largest in the free world. I think there are 250,000 employees involved in the Veterans' Administration. The budget is about $17 billion. Thirty-four percent of the population of the United States now will qualify for some type of veterans program or another. So, it is not a small operation.

We are involved in a question of third party coverage. As you know, currently, the veteran has the option of utilizing the veterans hospital facilities or medical facilities. He may have coverage under private health and accident policy that he carries or his employer may have that, but there is a covenant in that policy that prohibits the insurance company from paying the Veterans' Administration for reimbursement of care. The question of the propriety of that covenant has come up for discussion in the committee.

I am interested in your processing of insurance claims on behalf of those Alaskan natives for whom you provide care. I assume that those who do not have insurance are covered by the Indian Health Service Program in combination with the BIA, but my real interest is in those who do have insurance. Which way do you go? Do you go to the carrier or do you go to the BIA/IHS?

Mr. **Mather**. This is a problem that has also been evidenced in the Indian Health Service. For the past 3 years, the Congressional Appropriations Committee has ordered the Indian Health Service to bill third party payers. They have been unable to collect very many resources whatsoever because of the covenants that you mentioned.

Senator **Murkowski**. Those covenants are in insurance policies held by the American Indian people?

Mr. **Mather**. Yes, and that has been an obstacle. As a contractor, however, we have been successful to date in billing third party carriers. Most 638 contractors across the State have been successful in billing, with only one exception. To my knowledge there is only one insurance carrier which has refused payment on those grounds.

The Indian Health Service, for years in their Contract Care Program, has required the payment of other third party resources prior to Indian Health Service resources being collected.

Senator **Murkowski**. It is very interesting to note that the majority of the insurance carriers do go ahead and pay it. Evidently, then, it is a policy of IHS to pursue that, if an individual has the insurance coverage.

Mr. **Mather**. It is the policy of a tribally operated facility to pursue it. The IHS has been attempting to in their direct care facilities but they have not been very successful.

Senator **Murkowski**. Why have you been successful and IHS has not?

Mr. **Mather**. I think because we are not viewed as the Government when we pursue these claims. It is a bit ambiguous.

Senator **Murkowski**. You are certainly much more efficient.

In most cases, is the claim adequate to cover the cost? I would assume it would not totally cover the care.

Mr. **Mather**. Normally, there are co-insurance and deductibles that are not included which are then picked up by the Government.

Senator **Murkowski**. Are those then picked up by going back to IHS?

Mr. **Mather**. Yes.

Senator **Murkowski**. You have internally, then, in Tanana Chiefs Conference, the flexibility and you are proposing more flexibility, in which I concur. Basically, you are saving the Government an awful lot of money, are you not?

Mr. **Mather**. We are trying, not to save the Government money, but to increase the quality and the scope of the services.

Senator **Murkowski**. Let me put it this way. If you are collecting from the insurance company, and paying for the care, as opposed to the Government being billed for the care, it would certainly seem to me that you are simply calling on the insurance company which provides the coverage for payment as a consequence of the patient being enrolled in the coverage, and that is the function of insurance companies. They operate on the basis of actuarial realities. When they provide group coverage or individual coverage, they are taking into consideration the reality that they are going to have to pay some claims. But you are telling me that you are doing a better job with your Tanana Chiefs Conference inasmuch as you are able to bill back the insurance company for coverage to your people who do have that coverage as opposed to the IHS which you imply probably does not do as good a job or does not do it as often. That, to me, would mean that you are saving the Government a substantial amount of money.

Mr. **Williams**. We have more incentive to do it, too.

Senator **Murkowski**. What is your incentive, specifically?

Mr. **Williams**. Well, as tribal leaders, if we do not improve health and do a good job, we get fired.

Senator **Murkowski**. I am assuming the health care would be the same, ultimately, in either case. I am just looking at the source of the money. If the health care is provided by the private sector through your contractual arrangements, it does not really make too much difference who is paying for it. The health care, I assume, is of the same quality. But the point that I am looking at is, what do you do to get paid for it? You are going to those who have coverage while the IHS is perhaps not.

Mr. **Williams**. It vastly increases our ability to deliver health services if we can leverage it with insurance dollars.

Senator **Murkowski**. Well, you have made your point.

Mr. **Williams**. The installation of an appropriate management information system also aids greatly in the management of cases referred to the private sector as the IHS contract can budget by allowing maximum utilization of third-party resources.

Senator **Murkowski**. Well, maybe we can learn something from what you are doing. I am going to request that the professional staff do a little analysis, because whether it is the IHS or the Veterans' Administration, it is Federal money that is providing health care for either American Indians, part of which are the Alaska Natives, or veterans of our various wars. We seem to have a disparity here of procedure, and you seem to have designed a substantial improvement in the efficiency.

I know there is a question of attesting to the insurance company with regard to the financial liability and other things. But the realities are that you are getting return from the insurance company and some of the others are not. So, I intend to look at it a little further and see if we cannot draw some correlations and learn something.

I have one other question. What other comments on the legislation do you feel that you would like to see modified? I think there was some mention of the catastrophic provision.

Mr. **MATHER**. Yes. While we applaud the intent of the catastrophic provision, which I think is section 203, we feel that the way it is designed will not appropriately meet its intent. It is my understanding that the intent of the catastrophic provision was to provide some relief to service units of the impact of catastrophic patients on small service unit budgets so that they were not unfairly penalized by receiving a very high cost case.

My comment was twofold. First, the limits of in between $10,000 and $20,000, which were established, seem to be arbitrarily low as the cost of health care is accelerating at a pace where a $10,000 case is becoming more of a routine case than a catastrophic case. When that happens, when the cost of care is removed from the local level, the incentive to manage that case conservatively is also removed. So, by setting it at $10,000, you may be setting it arbitrarily low.

The second area is that the fund was supposed to apply to directly operated facilities as well as contract care. The impact of the catastrophic case on directly operated facilities is very, very little. They do not increase staffing. They do not increase the fuel oil bills. They do not increase the central cost of providing that facility. They are not accelerated by a catastrophic case.

The contract care budget, however, is a fee for service budget where these catastrophic cases can run $100,000 to $200,000. They do have a major impact. So, we would also recommend that the program be limited to the contract care budget.

Additionally, it is very difficult to determine the cost right now of a catastrophic case in a directly operated facility which could cause further complications.

Senator **MURKOWSKI**. Mr. Taylor, do you have any questions?

Mr. **TAYLOR**. No, I do not.

Senator **MURKOWSKI**. Thank you very much, gentlemen. We appreciate your testimony. We may be in further contact with you on the other matter that I mentioned.

Mr. **WILLIAMS**. Thank you, Senator.

[The prepared statement follows:]

PREPARED STATEMENT OF THE TANANA CHIEFS CONFERENCE, INC., SUBMITTED BY WILLIAM C. "SPUD" WILLIAMS, PRESIDENT

Tanana Chiefs Conference, Inc. is a Native Regional Corporation operating essentially all Indian Health Service programs serving the Interior of Alaska under a P.L. 93-638 contract. As President of the Board of Directors and Chief Executive Officer of the Tanana Chiefs Conference, I welcome the opportunity to submit the following testimony in support of the "Indian Health Care Amendments of 1985".

While the Tanana Chiefs Conference supports the entire bill, my remarks are directed specifically to Section 405, "Demonstration Program for Direct Billing of Medicaid and Medicare" which Tanana Chiefs Conference as a 638 contractor feels is critical to the success of our mission.

The Indian Health Care Improvement Act, which this bill reauthorizes, provided for the first time a declaration of policy of the nation to raise the health status of the Indian people to the highest possible level and to provide to the Indian Health Service the necessary resources to effect this policy.

In addition to declaring this policy, the Act in Section 701 required the Indian Health Service to begin a process (the Tribal Specific Health Planning Process) which would define the resources necessary for the Indian Health Service or tribally-operated health programs to insure a health status for Native Americans that is at a parity with the health status of the general population.

In April of 1980, Secretary Harris reported to Congress that this national planning process had documented a need for an additional $2.8 billion to provide services and insure a health status for Indians and Alaskan Natives that is at parity with the general population. The Secretary continued, however, to point out that this total which represents over three times the current federal budget for the Indian Health Service is the total needed from all Federal, State, Local and non-government sources. The plan continues to state that the maximization of these other resources is critical to the elimination of the deficiencies existing in the health services offered and the health status of Indians and Alaskan Natives.

Despite the recognition of the importance of these resources by Congress and the efforts of the Indian Health Service over the past four years to increase the availability of these resources, very few gains have been made. Collections for Medicaid and Medicare authorized by P.L. 94-437 have consistently fallen short of targeted levels and the resources collected from private insurance have been almost non-existent.

As a 638 contractor for IHS programs, the Tanana Chiefs Conference had planned to significantly increase the collection of other non-federal revenues to allow us to eliminate some of the serious deficiencies identified in our health delivery system in our P.L. 94-437 plan. Because of the restrictions placed on Tanana Chiefs Conference in billing Medicare and Medicaid by the Indian Health Service, this has been very difficult to accomplish.

We would request your support of Section 404, "Demonstration Program for Direct Billing of Medicaid/Medicare and other Third-party Payors". This program will allow us to prove that if local tribally-operated programs are given the responsibility and authority for collection of all alternate resources, significant gains can be made in the acquisition of these essential non-IHS resources which are necessary if the deficiencies in Indian Health care are ever to be eliminated.

Currently under our P.L. 93-638 contract, billings for Medicaid and Medicare visits to the tribally-operated Chief Andrew Isaac Health Center are made through the Alaska Native Health Service. This has proven to be an unacceptable arrangement as the Tanana Chiefs Conference has no authority or responsibility to insure that the billing process is carried out in an efficient manner.

In the past year we have learned that incomplete claims made on visits in the TCC facility that are returned by Medicaid for further information or clarification are not routinely followed up on by the Alaska Area office. Potential revenue from these claims is therefore not realized by the IHS or by the Tanana Chiefs Conference. Despite requests, we have been unable to determine what the outstanding accounts receivable for Medicaid and Medicare are in order to budget for the expenditures of these funds—estimate from the Alaska Area of outstanding receivables range from 180 to 360 days.

A major problem with the Area billing system which was pointed out by Tanana Chiefs Conference over a year ago remain unresolved and Area has been forced to retain a $2,000,000 M & M contingency against an unknown potential liability for double billings.

The IHS billing system does not have the capability or the authority to collect for numerous services provided by tribal physicians in the community hospital adjacent to the Chief Andrew Isaac Health Center, for dental care on Medicaid beneficiaries, and for services provided in field clinics in Alaskan Native villages. All of these problems which have been identified in the current IHS collection system for M & M seriously affect the ability of the Tanana Chiefs Conference to acquire the resources necessary to carry out our mission and all of these problems are outside the control of Tanana Chiefs Conference and cannot be corrected by us.

In order for a tribally-operated facility to collect third-party payments, a significant amount of resources and effort must be allocated to the development of an appropriate management information system to produce appropriately documented bills and adequate collection procedures. Although this process is expensive if appropriately designed, significant savings can be made in the expenditures necessary to input data into the IHS Patient Care Information System. Tanana Chiefs Conference has implemented a billing and patient data system that will transmit data directly to the IHS Patient Care Management Information System on magnetic medium. This eliminates the need for a contractor to manually enter this data at projected annual savings of $114,000 (based on IHS estimates).

It is important that incentives for the collection of third-party revenues be provided at the local level where they will be effective. The tribally-operated health program must expend a great level of effort to determine when third-party resources exist, to qualify individual patients for these resources, to develop an appropriate system for their collections and then to follow up on claims that were pended or denied due to inaccurate or incomplete information.

If the collection of these resources is to be maximized, the responsibility and authority for the above activities must be at the local level. In addition, a health facility must have incentives to reward and offset the cost of its efforts.

The successful collections of third-party resources also requires the cooperation and enthusiastic support of the tribal members themselves. If the resources gained by such efforts are returned to benefit all the members of the tribe, this cooperation is willingly given. When the resources are reallocated to another area which does not benefit the tribe, little cooperation is forthcoming.

The active incorporation of an adequate collection procedure for third-party resources by the tribally managed health system also allows increased utilization of these resources by individual patients. Many patients at the Chief Andrew Isaac Health Center live in isolated, rural villages. Often these patients have resources such as employer provided insurance but are unable to utilize them due to barriers created by distance from a private facility or by the complexity of the paperwork required for reimbursement. By providing an effective collection procedure, a more convenient location, and assistance in getting to the facility; the tribally-operated facility can increase the quality and scope of services available to the patient at little or no cost to the Federal government.

Tanana Chiefs Conference request two minor revisions in the proposed Section 404 as follows:

1. The period of the project be extended to five years from the currently recommended two years. It is difficult and costly to create an efficient billing and collection system. It requires a significant expenditure of resources on the part of the tribal contractor and the incentives for creating such a system for only two years would be marginal.

In addition, a successful program will require a significant and sustained public information campaign that requires two to three years to be fully assimilated by the public.

2. We would ask that Section 405(b)(1) be amended to read:

"(b)(1) Each hospital or clinic participating in the demonstration program described in subsection (a) shall be reimbursed directly under the medicare and medicaid programs for services furnished, without regard to the provisions of section 1880(c) and 1911(d) of the Social Security Act, but all funds so reimbursed shall first be used by the hospital or clinic for the purpose of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of such type under the medicare or medicaid program. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions or requirements shall be used solely for decreasing the health deficiency level of the tribe and not to reduce any funding to which the participant may otherwise be entitled in accordance with the regulations of the Indian Health Service applicable to funds provided by the Indian Health Service under any contract entered into under the Indian Self-Determination Act."

We are confident that the proposed study so amended will provide ample proof that the national goal of elevating the health services available to and the health status of the Indians and Alaskan Natives to parity with the general population is advanced by the placement of the authority and responsibility for collecting Medicare, Medicaid and other third-party revenues at the local tribally-operated health program.

Thank you for the opportunity of presenting this testimony.

Mr. **Taylor**. Our last scheduled witnesses are all from Montana. Before I call you forward, I would like to just comment that two other witnesses have asked to be heard, Mr. Burnett Whiteplume from Wind River and Allen Slickpoo from Nez Perce. We will call you after we have completed the prepared witness list.

From the Montana group, I would first like to call Ada White, president of the National Association of Community Health Representatives from Crow Agency; and Caleb Shields, member and former chairman, Montana Intertribal Policy Board in Billings, MT.

Ada, I understand you are accompanied by Connie Guillory. I guess we did not get that on our witness list.

Ms. WHITE. Yes; I am.

STATEMENT OF ADA WHITE, CROW TRIBE PRESIDENT, NATIONAL ASSOCIATION OF COMMUNITY HEALTH REPRESENTATIVES, ACCOMPANIED BY CONSUELO GUILLORY, NEZ PERCE TRIBE SECRETARY/TREASURER, NATIONAL ASSOCIATION OF COMMUNITY HEALTH REPRESENTATIVES

Ms. WHITE. My name is Ada White. I am a member of the Crow Tribe from the State of Montana. Currently, I am here presenting testimony on behalf of the National CHR Association of which I am president. On my right is Connie Guillory, a member of the Nez Perce Tribe from Idaho who serves as secretary-treasurer of the National CHR Association. We appreciate the opportunity to present testimony today specifically on behalf of CHR's that are employed throughout the country.

As we all know, Indian Health Service has applied most of its resources for primary health care. In addition to that, very often IHS resources are often seen as residual. When it comes to the application of community health representatives resources, we are first line tribal members providing direct contact between the tribal individual and the health resources. So, we have no way of saying we are residual or you come after you go to someone else. We are primarily the front line people who are involved in the delivery of tribal health program services.

Obviously, we know that in 1968, the CHR Program was established through the Indian Health Service by Congress as a way of responding to the special health needs of Indian people. We also know that the community health representatives and the value of the program is based on the fact that it employs tribal people and provides services that are tribal-specific, tribally designed, tribally relevant.

In 1968, the program was authorized through the congressional authority granted by the Snyder Act of 1921. The past 16 years, of course, it has been in existence based on the specific authorities of the Snyder Act.

We are concerned at this point in time that this past year we have survived because of the continuing resolution that was in effect. We are concerned and are cautious about the sunrise sunset effect of legislation. As a part of the proposed S. 277, where we are included as a component, our reservation would like to go on record that we do not want to be restricted again by the sunset effect of that legislation. If, indeed, it is given a specific time period for it to be alive, we hope not to be restricted by those time periods.

There are several other things that we would like to bring to the attention of the committee, and that is the fact that we do know the track record is there. In 1981, the CHR Program did indeed receive a 21 percent budget reduction. We do know that since 1982, the CHR Program has been repeatedly sought for complete elimination by the administration. We also know that health professionals, Indian Health Service personnel, Dr. Graham, and HHS have made public statements that the backbone of a comprehensive, effective health program is based on disease prevention, health promotion, and health maintenance.

If, indeed, those principles are to, in effect, be applied and perpetuated, then the resources that have been allocated to CHR Programs does do exactly what they interpret as being needed.

Currently, we, as a national association, are saying that we cannot endure any budget reductions. We are appreciative of the fact that we have retained our funding by the graces of Congress. We are appreciative of the fact that some of the key members of the Senate Select Committee have gone on record in strong support of the CHR Program. The past 2 years does bear witness to the fact that CHR Programs, tribal people, have worked in concert with Indian Health Service to respond to some of the congressional concerns that have been conveyed.

For example, the recent components that were developed to strengthen CHR accountability have been completed. There is a uniform reporting system and manual that has been developed, completed, and is waiting to be implemented. There is a training committee that has assessed the skill levels of CHR's and has determined more specific areas of training needs. There is a uniform scope of work guidelines that have been distributed nationally so that the criteria is the same for all programs which eventually will be evaluated. There is also a methodology that has been established to distribute CHR resources if there is an increase along the line.

Now, a lot of this work took a lot of energy from both CHR's, tribal people , and Indian Health Service. To see it go quickly down the drain is inconceivable to me. We are, at this point in time, looking to voluntary tribal compliance to go along with the uniform guidelines that have been established. We are looking to Indian Health Service to implement some of the suggestions that are being made.

We do know that in some areas we have some Indian Health Service area personnel that are dragging their feet to implement some of the suggestions that have been made by the Indian Health Service and the National CHR Association. It is our hope that both area personnel and tribal personnel will see the need to streamline some of the programmatic changes we have developed so that the accountability is there that we can come before Congress with the exact measurements of cost effectiveness, medical efficacy, how money was spent, and where it was spent.

We do know that the track record is there. We have done a good job. We are on the front line. We are doing a lot of things, but unless we have a centralized storing house of information, a lot of what we say can be just set aside.

We are recommending that we not be reduced any more in funds, that indeed we be kept at the same level. If there is a way to increase funds, then certainly we would request a cost of living increase.

No. 2, we would request specific funds be set aside for a national reporting system and training center. No. 3, we would also recommend that the line item identification of the CHR allocation be retained. We know that Indian Health Service has a track record of manufacturing obstacles in applying legislation or policy or what have you. We are concerned that if money is not specifically earmarked, that the room to play games with it would be anticipatory and could again result in our coming before a Senate committee requesting and recommending changes.

Connie, if you have any comments to make, at this point I would defer to you.

Ms. GUILLORY. What I would like to refer to is, I have always been told you do not come before a committee and tell horror stories, things that actually happen. But, I feel that I must in line with our testimony. Again, it is not down on paper. I can not give it to you and say this is what has happened. However, I am going to give you some examples just on the Nez Perce Reservation.

We are front line people. We are out there working in the community, and we get calls at all hours of the day and night. It is too bad people do not get sick from 8 a.m. to 4:30 p.m. but they do not. It is too bad people need an ambulance, but they do, or a CHR.

I received a call one morning. It was about 7 a.m. This lady was bleeding profusely from the nose. So, we went up to her home and because of the time of day, by the time we got there at 7:30, I said gee, we would be saving IHS money. She wanted to go to the emergency room in Lewiston, which is 13 miles away. I was looking at the time, thinking I am going to help IHS, I am going to save them money. So, we went over and we waited till 8:00 and got her into the clinic. I do not know what an emergency room cost is. We do not work at that end, but we did save IHS money. We walked her right across to the clinic.

About 2 months ago, a patient who had been up in Spokane, which is 250 miles round trip from Lapwai, had been residing up there. IHS was paying the cost plus Medicare. We received a call stating this person was ready to come home. You need to transport him. So, we went to get him, not realizing we were bringing home a dialysis machine. We saved money again; 250 miles times 20.5 cents came to $51.20. I would like IHS to look at that and tell me what that would have cost them.

We could go over example after example. We have a patient up river who has cancer. She has to have blood transfusions. She is allergic. She has reactions. The CHR transports this person from outside of Kamiah to Orofino and back. There again we are saving the IHS money, yet to give it to you on paper, to get credit for it through IHS, we do not get it but we are out there. I feel it is very unfair for Dr. Graham to just blatantly say it is not that we do not support the CHR Program, but we are in primary care. How can he equate that with a cost saving?

We have never been asked, CHR's have never been asked, from the clinical settings. For the past 4 years, we have not had training. IHS said we cannot send you to the training centers anymore. So what are CHR's having to do? They are going through the public health nurses and the IHS clinics. They are receiving training on the reservation or close to it. Again, there we are as CHR's taking that first step. It is not IHS telling us; we are doing it.

I had a chance to look at Senator Bingaman's bill on health promotion, disease prevention, and health maintenance. It looked like it was written for the CHR's. We do it, except that we have not specifically stated what we shall do under health promotion, this type of thing. But CHR's are doing it, and we support that bill. I could not believe it. I told Ada, I said, why are they saying all this? This is what CHR's do.

So, hopefully, that will be passed or it can just say CHR's, because that is what CHR's are doing across Indian country.

Thank you.

Ms. **ZELL**. Three out of the four provisions that are contained in Senator Bingaman's bill are contained in the Indian Health Care Improvement Act reauthorization. It is the intent of both bills that the CHR's play a vital role in carrying out those health promotion and disease prevention services.

I would like to make clear that the reason that S. 277 adopts the approach and expresses the intent of Congress that the CHR Program is to be funded under the Snyder Act, is to make that program a permanent program of the Indian Health Service so that should this bill be signed into law, it would no longer be necessary for the CHR Program to be reauthorized in future years. While that will not resolve the fights for the budgetary existence of the CHR Program each year, it should at least make clear the strong support of Congress for the CHR Program and the recognition of Congress that this program is a vital and crucial component of the health care delivery system to Indian people.

Ms. **WHITE**. Thank you very much for this opportunity to present our testimony. We do know that there are some reality factors that are not going to change. The remoteness of Indian villages is going to be there. The lack of paved roads on Indian reservations is going to be there. Obviously, the intent to provide some way to acquire permanency for the program is indeed heartening and we certainly appreciate it.

Thank you.

Ms. **ZELL**. Thank you.

[The prepared statement follows:]

PREPARED STATEMENT OF ADA M. WHITE, CROW TRIBE PRESIDENT, NATIONAL ASSOCIATION OF COMMUNITY HEALTH REPRESENTATIVES, AND CONSUELO GUILLORY, NEZ PERCE TRIBE SECRETARY/TREASURER, NATIONAL ASSOCIATION OF COMMUNITY HEALTH REPRESENTATIVES

Mr. Chairman, my name is Ada White. I am a member of the Crow Tribe from the State of Montana. I appreciate your concern and the opportunity provided for this statement to be presented.

Historically, Indian Health Service has focused its resources on primary health care. In response to the special health needs of the Indian and Alaskan Native populace, the Community Health Representative (CHR) Program was initiated.

The Community Health Representative (CHR) Program was established by Congress in 1968, through the Congressional authority granted by the Snyder Act of 1921 (42 Stat. 208, 25 U.S.C., 13). The past sixteen (16) years bear witness to the evolution of a Tribal health delivery system providing much needed services in the areas of disease prevention, health promotion and health maintenance. In 1981, the Administration proposed and achieved a 21% reduction in funds for CHR Programs. Since 1982, the Administration has repeatedly requested the complete elimination of the CHR Program, but through the awareness, concern and sensitivity of the august members of Congress, the CHR Program has managed to survive and has continued to provide the much needed health services to Indian people and Alaska Natives on remote reservations and villages in the United States of America.

Some areas in which CHRs continue to provide health care in are: (1) the provision of direct care services; (2) the development of Tribal programs utilizing CHR services in identifying symptoms and stages of various diseases; (3) disease interception approaches reducing and/or preventing costly hospital care; (4) maintenance of stable, health home environments; (5) provision of health education to reinforce vital preventive health programs; and (6) emergency medical response and transportation services.

More importantly, the application of the CHR resources and its effects can be seen in: the reduction of average patient load in 1968 was 2,747 and as of 1983, 1,515; an increase in out-patient clinic visits of 1.6 million visits in 1968 to 4.1 million in 1983; an increase in the immunization of children has been achieved at the 90% level; first tri-mestor visits has shown an increase of 13.3%; and the CHR Program has provided skilled manpower necessary to operate Tribal emergency medical services by 60%.

The Honorable Senator Jeff Bingaman, New Mexico, in introducing a bill titled, "Indian Health Promotion and Disease Prevention Act of 1985," focused our attention on the need for a "Comprehensive Health Promotion and Disease Prevention Services," the section pertaining to the Community Health Representatives, did point out some factors which attribute to the unique qualities of the CHR Program and they are: CHRs are members of Indian communities, trained and employed as health para-professionals; activities of CHRs being Tribal specific and relevant to community needs. Further, the entire section is reflective of the CHR Program.

The past two years have shown the committment of CHRs and Indian Health Service in addressing programmatic changes impacting needed management revisions: the development of a uniform reporting system; a training committee established to assess the current skill level of CHRs and to define training needs; the allocation of CHR resources based on program effectiveness; uniform guidelines and scopes of work. These procedures were established whereby Tribal input was ascertained in each phase of development. The result of the work needing to be accomplished in each of the forementioned areas at this point rest solely on voluntary Tribal compliance. It is our hope the Indian Health Service and Tribes continue to be supportive knowing that the end result will be the accountability of CHR resources in terms of medical efficacy and cost effectiveness.

The CHR Programs throughout the country are seeking the support of Congress on the following recommendations:

1. Maintaining the current level of funding for CHR Programs; 2. establishing and funding a strong training curriculum that has been sorely neglected; and 3. funds for a national reporting system.

We can assure you that the work we are doing makes a difference in the health care of our people and we look forward to coming before you to affirm this position at next year's appropriation hearings.

Mr. TAYLOR. Mr. Shields.

STATEMENT OF CALEB SHIELDS, MEMBER AND FORMER CHAIRMAN, MONTANA INTERTRIBAL POLICY BOARD

Mr. SHIELDS. Thank you.

I am here representing the Montana Intertribal Policy Board. I am also a member of the Fort Peck Tribe's executive board. On behalf of the Montana Intertribal Policy Board, I would like to thank the committee for the opportunity to present our views on S. 277.

It is always a pleasure to testify before this committee. Last year, the Congress passed S. 2166, a bill to reauthorize and amend the Indian Health Care Improvement Act. The board strongly supported that bill and greatly appreciates the fine work of this committee in achieving its passage. That bill should be law today but it was vetoed. Unless there is further congressional action, this veto will place Federal and tribal efforts to improve the health of the Indian people in serious jeopardy.

The board calls on President Reagan and officials from the Department of Health and Human Services to work closely with this committee and the relevant committees in the House to enact a bill that will meet the health needs of the Indian people.

In my testimony, I will concentrate on the provisions in the bill that were featured most prominently in President Reagan's veto message. Also, for the convenience of committee members and staff, I have attached copies of the board's prior testimony last March and April on S. 2166 and also H.R. 4567 which discusses all of the provisions in detail.

Title VI, organizational improvements, would remove IHS from the jurisdiction of the Health Resources and Services Administration and make it an agency within the Public Health Service. Title VI of S. 2166 was similar but would have created an independent commission to study the matter. According to President Reagan, the provision establishing the commission was unconstitutional, now a moot point because this provision has been deleted. What disturbs us is the President's statement that the proposed reorganization would be wasteful and unnecessary.

The reorganization provision has strong support from individual tribes, from Indian organizations, and professionals who have worked with IHS. As we discussed in our testimony last year, IHS has been plagued with management problems which title VI of S. 277 would do much to solve. This title would give the IHS Director a stronger voice in budget and policy matters and remove several layers of bureaucracy and red tape from decisions affecting Indian health. Title VI would also give the IHS Director responsibility for personnel and procurement matters which would eliminate the ill-advised decisions and delays we have seen in these areas in the past.

We simply cannot understand why this provision, which involves no new expenditures and would also almost certainly save money, has not been supported by the administration. We will work with the committee in any way we can to resolve this matter.

In the area of section 204 of S. 2166, the Montana demonstration project, S. 277 does not contain a provision comparable to section 204 of S. 2166, which is often referred to as the Montana provision. However, because President Reagan based his veto in part on this provision, and because there is still considerable committee interest in the provision, I will discuss it briefly.

Section 204 was placed in S. 277 by Senator Melcher in an effort to resolve a dispute between Montana counties and IHS. Individual Indians have been caught in the middle of this dispute, and the board greatly appreciates Senator Melcher's generous efforts on their behalf.

The board supports section 204 because provision of health services to Indians is part of the Federal trust responsibility. Section 204 acknowledges this by requiring the Federal Government to provide health services to Indians without regard to their possible eligibility for State and local programs. Of course, like other citizens, Indians are entitled to State and county services, but when it comes to health, the Federal Government must be the primary provider. The board feels so strongly about this issue that it asks that section 204, if it is included in S. 277, be amended to reaffirm the Federal trust responsibility with regard to health services.

Also, I would like to add at this time, that hearing all of the other testimony from the tribes and organizations and some of the tribes being placed in the position to either oppose or support the

Montana provision, I have been getting very upset with what Indian people have been trying to address, and that is the trust responsibility, and either taking a position of opposing or being for it.

It is like the old saying about a woman that she is only a little bit pregnant. If you believe in treaties and Executive orders, you just can not believe in them a little bit. You either believe in them or you do not believe in them. I feel that if Indians yield an inch on the trust responsibility issue, then what we are actually saying is that we agree with President Reagan that there is no trust responsibility there as a primary provider. I would hope that rather than tribes being put in the position to either oppose or support the so-called Montana provision that they would think through what trust responsibility, what treaties, are all about and, No. 1, understand what the Montana provision is before they make statements of opposition.

As I have testified here, we would hope there would be an amendment in the act to reaffirm the Federal trust responsibility with regard to health services. Now, with the infinite wisdom of the committee, if the committee and the Senate do not provide an amendment with a provision similar to Senator Melcher's amendment, the Montana provision, then, as an alternative—and I think Senator Melcher has to be commended for bringing and surfacing this as an issue that the Senate and the tribes have to face. It is not very many times that we get a Senator who would come out and say that he believes in the treaties and he is going to fight for the Indian tribes and the Indian people for what we have been saying all these years.

It is very similar to the Northwest tribes. They have been fighting for fishing rights. In cases like this, maybe they do not believe it as much as a fishing right is a trust responsibility.

But in any case, we have to, I think, offer some type of a solution to the problem. We cannot ignore it just by opposing a problem. We have to offer some type of alternatives to deal with it that would benefit not only what most people say would benefit not only Montana. I think Senator Melcher is saying it would benefit many, many more tribes than just those in Montana.

As an alternative, I would suggest that to deal with the problem directly the committee should maybe amend into the act some directives to the Indian Health Service to do a report and require them to negotiate with the State, the counties, and the tribes on this particular issue that has been raised. Those things that they can solve administratively they should be directed to do. Those things that they cannot solve administratively they should be required to report back to the committee with specific recommendations and possible future legislation that would resolve that problem and not just continue to ignore it.

I might add a little bit more about the Indian Health Service being required to do a report. I am really not in favor of IHS investigating itself, the same as I am opposed to the BIA investigating itself. Maybe there should be some allowance for the GAO or somebody, another agency, to oversee it. But, in any case, this committee may require an internal report within a given period of time so progress can be measured on what they are doing to resolve this problem.

Again, I do personally want to commend Senator Melcher for bringing this problem to the surface and getting tribes to address it. I hope we will see other tribes submitting testimony for the record, addressing the issue the way I am, rather than just opposing it or supporting it. There should be alternatives to it.

The Montana Intertribal Policy Board is pleased that the Montana State Legislature has demonstrated its concern for the health of its Indian citizens through consideration of State Senate Joint Resolution 22, which I may add is a tribal initiative, calling for reauthorization of the Indian Health Care Improvement Act. This resolution, a copy of which is attached, passed the State senate by an overwhelming margin and has now been referred to the House where we expect the same result. The overwhelming margin in the State senate was when it passed last Thursday, and the vote was 48 to 2 on that measure. It has now been transmitted to the State house of representatives in Montana, and we should hear within the next couple of weeks of their action on it.

I do have it attached for the committee record at the end of this testimony. This was a senate joint resolution that we had asked State Senator Tao and State Senator Bill Yellowtail of the Crow Tribe to sponsor which they agreed to do.

This came about last October, the week after Reagan vetoed the reauthorization act. We were having our annual intertribal conference in Billings that following week. Senator Melcher was our speaker at our intertribal conference, and we had discussed making a tribal initiative on getting the State to support the reauthorization of the Indian Health Care Improvement Act. At the same time, we had gone on record with a draft position paper very clearly stating the strong support for the Montana provision.

In the area of the Community Health Representative Program and the urban Indian health services under title I and title V respectively, President Reagan criticized S. 2166 because it would place increased emphasis on services that are not oriented toward the primary mission of the Indian Health Service. Although President Reagan did not list the services that he regards as outside IHS' primary mission, the board has concluded, based on other statements by the administration, that these services include urban health programs and the CHR Program. I would like to express the board's strong support for these important programs.

The board has frequently expressed its strong support for the urban health programs as an essential part of the federally funded health system for Indians. I refer the committee to our previous testimony on H.R. 4567 for a detailed discussion of our position on this issue. Furthermore, we support S. 277's placement of the urban health programs under the Snyder Act as an appropriate recognition of the fundamental importance of these programs.

S. 277 would amend title I of the Indian Health Care Improvement Act to place the community health representative program under the authority of the Snyder Act and provide guidelines to IHS in administering the program. S. 2166 had no similar provision.

The board strongly supports the CHR Program. It provides necessary followup services for patients recovering from surgery and allows IHS to monitor those with chronic health problems, and permits early identification and treatment of new problems. All of these services allow IHS to fulfill its primary mission much more effectively. We are concerned that President Reagan will oppose this provision because he has consistently sought to eliminate funding for the CHR Program.

Under section 702, the juvenile alcohol and drug abuse section, that section would require the Secretary of the Department of Health and Human Services to take several important steps to combat drug and alcohol abuse. The board supports this provision, particularly the portion of it that would provide training for teachers in schools on or near Indian reservations. With appropriate training, these teachers would be a valuable resource in our fight against drugs and alcohol abuse.

However, I would like to point out that Montana tribes have a pressing need for trained counselors to work full time with the young people suffering from severe drug and alcohol problems. These young people, many of whom have had problems with the law, need intensive counseling over an extended period, which only full time professional counselors can provide.

On the Fort Peck Reservation, for example, there is a modern facility to house juvenile offenders, many of whom have drug and alcohol problems, but there are no funds for counselors. Therefore, the facility is nothing but a lock-up. The teachers who would be trained under section 702 would not have the time or the training to fill this need.

We realize that in a time when spending cuts are high on the congressional agenda, it is difficult to obtain additional funds for any program. However, we believe that providing more counselors now would save money in the future, because fewer people would go on welfare and need treatment for health problems related to drug and alcohol abuse. Therefore, we urge the committee to authorize sufficient funds to provide a reasonable number of additional counselors. The committee could do this by amending S. 277 or may prefer to address this issue when it considers H.R. 1156, a House bill dealing with the problem of drug and alcohol abuse among Indian youth.

In closing, the board strongly supports this committee's efforts to reauthorize and amend the Indian Health Care Improvement Act. I would also like to say that in working with the Montana provision and Senator Melcher's proposed amendment, we also would like to offer any assistance that we can to provide necessary language for consideration just in case this committee and the Senate does not adopt Senator Melcher's current amendment.

Thank you.

Mr. TAYLOR. Mr. Shields, I would like to thank you very much for the statement and the comments on the Melcher amendment.

In the context of the CHR matter that was testified to earlier, my sense is that it has been a very popular program despite several years of efforts to eliminate funding for the program. The Congress has not seen fit to do so, and, frankly, it is one of the most important portions of the Indian Health Care Reauthorization Act. It is a very popular program, and I have no doubt about congressional support for it.

Mr. **Shields**. I would like to add one more thing. I met a lady from Montana who will be testifying. There will be two ladies representing some agencies and associations within the State.

I wish that we could really find out what the problem is. I know there are serious problems on payments, and this is what I am saying. We have to look at the wide dimension of the problem, get all the aspects of it and the problems that are associated with it, because, for the most part, I think Indian people and the tribes themselves do not really understand what is going on in this particular area.

In one case, you may hear figures about this and then someone else may refute them. So, we end up not knowing what to believe. I think we have to document all these things and come up with some solutions rather than, as I said earlier, just opposing something. It is a pressing problem. It is a serious problem. I think it would warrant, as I had suggested, a GAO look, or at least further committee work on it, so we can get a final resolution to it.

The problem is not going to go away. The sooner and the faster that we deal with it, I think, the better it is going to be for the tribes, and especially the clients who are now being denied services. We have to resolve that problem. We can not let it continue.

Thank you.

Mr. **Taylor**. Thank you. I think that is very wise counsel. I am very sure that we will be considering that as we move forward with this.

Thank you very much.

The documents you submitted will be made part of the record at this point.

[The documents follow. Testimony resumes on p. 368.]

Senate JOINT RESOLUTION NO. 22

INTRODUCED BY Yellowtail

BY REQUEST OF THE SENATE PUBLIC HEALTH,

WELFARE AND SAFETY COMMITTEE

A JOINT RESOLUTION OF THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA URGING THE UNITED STATES CONGRESS TO REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT.

WHEREAS, the Indian Health Care Improvement Act was passed in 1976 with the purpose of improving Indian health to the level enjoyed by other Americans; and

WHEREAS, for the past 8 years, the Indian Health Care Improvement Act has been an important source of funds for vital Indian health programs, including clinical care, alcohol and mental health programs, training and recruitment of health personnel, and facilities construction; and

WHEREAS, the Act expired on October 1, 1984; and

WHEREAS, although significant progress has been made, the purpose of the 1976 Act to improve Indian health to the level enjoyed by other Americans remains to be achieved; and

WHEREAS, severe problems such as infant mortality, alcoholism, diabetes, tuberculosis, and hepatitis remain much more serious among Indians than among other Americans, including those in the State of Montana; and

WHEREAS, many Indian health facilities are in a shocking state of disrepair, and many needed facilities have yet to be built, including facilities in the State of Montana; and

WHEREAS, many Indian communities, including those in the State of Montana, lack necessary sanitation facilities; and

WHEREAS, on many Indian reservations in Montana there are serious shortages of health personnel and equipment, and the sanitation facilities need substantial improvement; and

WHEREAS, in recognition of the continuing health needs recited above, Congress in October of 1984 passed a bill to amend and reauthorize the Indian Health Care Improvement Act; and

WHEREAS, this bill would have established important new programs, including a Catastrophic Health Emergency Fund; and

WHEREAS, in spite of the great need for reauthorization of the Indian Health Care Improvement Act and the broad bipartisan support for the bill, President Reagan vetoed the bill; and

WHEREAS, the State of Montana has a vital interest in the health of its Indian citizens; and

WHEREAS, the State of Montana is concerned that if Congress does not reauthorize the Indian Health Care Improvement Act early in 1985, appropriations for Indian health programs will be drastically reduced, with disastrous effects on the health of American Indians, including those in the State of Montana.

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA:

That the Montana Legislature calls upon the United States Congress to reauthorize the Indian Health Care Act and upon President Reagan to sign it into law.

-End-

March 22, 1984

TESTIMONY OF THE MONTANA INTER-TRIBAL POLICY BOARD ON H.R. 4567

Mr. Chairman, I am Caleb Shields, the Chairman of the Montana Inter-Tribal Policy Board. On behalf of the Board, I would like to thank the Committee for this opportunity to present our views on H.R. 4567, a bill to reauthorize and amend the Indian Health Care Improvement Act.

Congress passed the Indian Health Care Improvement Act in 1976. The findings Congress made as part of that statute presented a grim picture of health and health care among the Indian people. The health status of Indians was far below that of other Americans, and the available services did not reach many of the Indians' most critical health needs. Although federal services to Indians had produced some improvement in the situation, Congress found that inadequate and outdated facilities and equipment, a serious shortage of personnel, and insufficient services prevented truly significant advances.

The goal of the Indian Health Care Improvement Act was to raise the health status of the Indian people to a level equal to that of other Americans. I regret to say that this goal has not been accomplished. Although substantial progress has been made, Congress could make many of the same findings today as it made in 1976. There are several reasons for this. First, appropriations have fallen far short of the amounts authorized by the Act. Second, the overall budget for IHS has been cut since President Reagan took office. As a result, many tribes have found it difficult to maintain the level of health services, much less improve those services as the Act contemplated.

Clearly, then, the Act must be reauthorized, and the Montana Inter-Tribal Policy Board strongly supports reauthorization. We also urge Congress, in reauthorizing the Act, to maintain the Act's original goal -- to make Indians as healthy as other Americans. Nothing less will do. It is all very well to speak, as President Reagan has, of strong reservation economies and tribal self sufficiency. But we will never come close to achieving those lofty goals if we cannot achieve a much more basic one -- sound physical and mental health for the Indian people.

I would now like to discuss our specific concerns about the bill.

Reauthorization of Title II (Section 201(a)-(d))

Title II of the Indian Health Care Improvement Act authorizes additional funds for certain health programs in order to eliminate backlogs and supply unmet needs. H.R. 4567 would add community health representatives, alcohol rehabilitation, and accident prevention to the list of programs eligible for additional funds under Title II. The Board wholeheartedly supports addition of these programs, particularly alcohol rehabilitation, which is of major concern to Montana tribes.

H.R. 4567 would significantly change the approach of Title II. Instead of authorizing specific amounts of money for individual programs, the new Title II would authorize one overall appropriation based on the amount required to raise all tribes to at least Level II of the Indian Health Service Priority System. The amounts allocated to particular program categories would depend on actual tribal needs, with the neediest tribes having the highest priority. To assist in the authorization and distribution of funds, IHS would be required to identify each tribe's level on the priority system and the funds necessary to raise these tribes to Level II, Level I, and the zero level.

The Board supports the concept of needs-based authorization and allocation of funds. We are particularly pleased that H.R. 4567 would require IHS to identify unmet health needs and the funds required to meet these needs. However, we are concerned that H.R. 4567 replaces the goal of equality with the much more modest goal of Level II on the priority system. Although the words "at least Level II" are used, the bill's message is that Level II, rather than equality, is now the benchmark under the Act.

Many Level II tribes lack 40% of the resources they need to achieve equality of health care with other Americans. We understand the Committee's concern that Congress may be reluctant to pass a bill authorizing significant new spending. However, the goal of equality is of such vital importance that it must not be abandoned, particularly at the outset of the reauthorization process. We must fight as long and hard as necessary to achieve this goal.

Accordingly, we suggest that the authorization provision be amended to authorize such sums as necessary to raise all tribes to a zero level of deficiency, or at the very least, Level I. Such an amendment, in combination with the needs identification provision, would have the double advantage of retaining the goal of equality while forcing IHS and Congress to acknowledge what funds are needed and the hardship that will result if the appropriations are insufficient. If Congress later chooses to appropriate only enough funds to raise tribes to Level II over

Urban Health Services (Section 501)

H.R. 4567 would reauthorize Title V of the Indian Health Care Improvement Act, which created health programs for urban Indians. The Administration wants to eliminate the urban health programs, claiming that IHS' primary responsibility should be to Indians living on or near reservations, and that in any event urban Indians can obtain the same services from other sources.

We could not disagree more strongly with the Administration's position. Many Montana Indians leave our reservation to seek work in the cities. As the administration is well aware, this is often a matter of economic necessity. However, when these members cannot find the health care they need in the cities, they go without care until a serious problem develops and then return to the reservations to seek help. We have seen this pattern develop as a result of the cuts in the urban health budget over the past several years. This ends up costing IHS more than adequate urban health programs would.

Also, when an Indian is laid off from his city job and cannot find other work, he may well return to the reservation, at least temporarily. This, along with the fact that Indians return to the reservation to seek needed health care, shows that there is no sharp division between urban Indians and Indians on or near reservations. In most respects they are part of the same community. If IHS is to fulfill its acknowledged responsibility to the latter group, it must also provide services to the former.

As for the Administration's claim that urban Indians can obtain needed services from other sources, this claim has been soundly refuted by both the urban health organizations themselves and the groups that supposedly provide the alternative resources. We are confident that testimony from groups such as the Community Health Center Association and the American College of Obstetricians and Gynecologists will provide the Committee with ample support for its proposal to reauthorize Title V.

The Senate version of the bill to reauthorize the Act authorizes enough funds to expand urban health programs significantly. However, H.R. 4567 only authorizes very small increases, which we doubt would even cover inflation. Urban health programs have been chronically underfunded, and we urge the Committee to raise its authorization levels so as to permit expansion of these programs.

the next three years, it can do so, but the Act should not sanction this deficient action.

Catastrophic Health Emergency Fund (Section 202)

The Board agrees that a Catastrophic Health Emergency Fund should be established. In Montana, there have been a number of cases where catastrophic cases have substantially depleted contract care budgets -- for example, an infant needing multiple surgeries and other expensive treatment at a facility in Billings, one hour from the reservation by air ambulance. Situations such as this are impossible to plan for at the local level, and a central catastrophic emergency fund would enable tribes to handle catastrophic cases without denying care to other patients.

However, we have one concern that could be addressed through an amendment to the bill. We fear that if the catastrophic health care fund is authorized, IHS in future years will simply offset the $15 million authorized for the fund against the remainder of its appropriation request. Since most catastrophic illness is treated through contract care, the reduction would probably come in that portion of the budget, which is already grossly inadequate.

The bill should be amended to make clear that the $15 million for the catastrophic health care fund is in addition to the remainder of the IHS appropriation. This could be accomplished by adding to Section 202 the language from Section 201(a) of the bill, which prohibits funds appropriated under that section from being used to offset or limit appropriations under any other authority. Of course, the Committee will then have to monitor IHS' compliance with this provision when it submits its proposed budget.

Reauthorization of Title III (Section 301)

Title III of the Indian Health Care Improvement Act authorizes, *inter alia*, funds for contruction and renovation of IHS facilities. The Board approves of the provision of H.R. 4567 that would target the funds to the highest priority facilities, both inpatient and outpatient. However, we understand that the Committee originally planned to authorize sufficient funds for the top ten facilities on the two priority lists, rather than the top five. Given the tremendous need for new and renovated health centers in Indian country, including in Montana, we urge the Committee to amend the bill to conform to its original intentions.

Service to Noneligible Persons (Section 710)

The issue of eligibility for IHS services is a very difficult one. H.R. 4567 does not attempt to redefine eligibility completely, but would allow certain groups not eligible under the present guidelines to receive services under specified conditions.

As we understand it, IHS already provides services to many ineligible minor children of eligible Indians, but would like specific authority to do so. The Board has no objection to this as long as the increased service load is reflected in the appropriation for health services, which appears to be the objective of Section 710(b). If it is not, then the tribes should be able to decide whether they want to divide up their already inadequate resources even more finely.

We regard Section 710(c), concerning ineligible spouses, as a stopgap provision. Under this section, tribes could authorize provision of services to ineligible spouses of eligible Indians, but their allocation for health services would not increase. The Board agrees that if IHS funds are not increased to accommodate ineligible spouses, then the tribes should have the decision on whether to provide services. However, we also believe that this issue needs to be addressed more directly, because the many tribes that favor provision of services to spouses of eligible Indians may be deterred from permitting this by the strain it would place on IHS resources on their reservations. We believe that if the majority of tribes favor providing services to these spouses -- and I note that the information available plus common sense indicates that such provision would have a positive effect on the health of Indian families -- then spouses should be made an official part of the IHS service load and IHS funds should be increased accordingly.

Under Section 710(d), IHS could provide services to any ineligible person within a service area, if, among other conditions, the tribes involved concurred and the ineligible persons paid a fee amounting to the actual cost of the service. The Board is concerned that tribes will concur because they will believe that the fees will cover the full cost of the service and therefore services to Indians will not be diminished. However, it may not be realistic to set a fee that will cover the service itself, a fee for the physician or other professional, and all overhead costs, particularly if the persons being served do not have insurance. If, as is likely, the fees are not collected in many cases, service to Indians will be adversely affected.

In short, the Board is not convinced that the need for Section 710(d) is so great as to justify the risk of diminishing services to Indians. Therefore, we cannot support this provision at this time.

Office of Indian Health Affairs (Title VIII)

The Board fully supports Title VIII of H.R. 4567. Creation of an office of Indian Health Affairs would go a long way toward solving the management problems that have plagued IHS. First, the IHS director is too far down in the agency hierarchy to have a strong voice in budget and policy decisions. All too often, these decisions are left to those whose primary interest is not Indian health and who do not understand the unique problems in the Indian health field. This results in ill-advised policies that are completely unworkable in Indian country and that are frequently overruled -- but not before causing substantial disruption at the tribal level. Also, the IHS Director must contend with several layers of bureaucracy in getting clearance for release of information, which results in substantial delays in responding to questions posed by Congressional committees, performing studies and making reports required by statute, and the like.

Second, two of the most important functions related to Indian health -- personnel and procurement -- are in the hands of government officials who are not even in the same chain of command with the IHS director. Once again, this results in ill-advised decisions and substantial delays. Title VIII of H.R. 4567 should help solve all of these problems, and we strongly support its enactment.

Clinical Care Priorities, Health Advisory Board and Competitive Bidding (S.2166)

The Board is submitting testimony to the Senate Select Committee on Indian Affairs concerning S.2166, the Senate bill to reauthorize the Indian Health Care Improvement Act. In this testimony, a copy of which will be forwarded to this Committee, we will support three provisions that do not appear in H.R. 4567 -- the clinical care priorities provision (Section 705), the Indian Health Care Advisory Board provision (Section 706(a)), and the competitive bidding provision (Section 708). We suggest amendments to each provision. We urge this Committee to review our Senate testimony and add amended versions of these provisions to H.R. 4567.

Payment for Health Services to Indians Rendered by State and Local Programs in Montana

We will address this issue, which is raised in Section 707 of S.2166, in our testimony on that bill. As previously noted, a copy of that testimony will be furnished to this Committee.

That concludes my testimony. I would be glad to answer any questions you may have.

April 17, 1984

Honorable Mark Andrews
Chairman, Select Committee on Indian Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Andrews:

The Montana Inter-Tribal Policy Board writes to express its views on S. 2166, a bill to reauthorize and amend the Indian Health Care Improvement Act. Please add our views to the record of the Committee's hearings on this bill.

Congress passed the Indian Health Care Improvement Act in 1976. The findings Congress made as part of that statute presented a grim picture of health and health care among the Indian people. The health status of Indians was far below that of other Americans, and the available services did not reach many of the Indians' most critical health needs. Although federal services to Indians had produced some improvement in the situation, Congress found that inadequate and outdated facilities and equipment, a serious shortage of personnel, and insufficient services prevented truly significant advances.

The goal of the Indian Health Care Improvement Act was to raise the health status of the Indian people to a level equal to that of other Americans. I regret to say that this goal has not been accomplished. Although substantial progress has been made, Congress could make many of the same findings today as it made in 1976. There are several reasons for this. First, appropriations have fallen far short of the amounts authorized by the Act. Second, the overall budget for IHS has been cut since President Reagan took office. As a result, many tribes have found it difficult to maintain the level of health services, much less improve those services as the Act contemplated.

Clearly, then, the Act must be reauthorized, and the Montana Inter-Tribal Policy Board strongly supports reauthorization. We also urge Congress, in reauthorizing the Act, to maintain the Act's original goal - to make Indians as healthy as other Americans. Nothing less will do. It is all very well to speak, as President Reagan has, of strong reservation economies and tribal self-sufficiency. But we will never come close to achieving those lofty goals if we cannot achieve a much more basic one - sound physical and mental health for Indian people.

We now discuss our specific concerns about the bill.

Reauthorization of Title I, Indian health manpower.

The Board fully supports reauthorization of health-related scholarship and recruiting programs for Indian students. IHS programs in Montana have chronic difficulty in filling professional staff positions, particularly for physicians. The long term solution to this problem is increased funding for training of Indian health professionals. Right now, intensified recruiting efforts are needed. S. 2166 approaches the problem from both directions by authorizing increased appropriations for both scholarships and recruitment. The increased appropriations are crucial, and we support the authorized levels in S. 2166 rather than those in H.R. 4567, which are much lower.

Reauthorization of Title II, Health services.

Title II of the Indian Health care Improvement Act authorizes additional funds for certain health programs in order to eliminate backlogs and supply unmet needs. S. 2166 would add community health representatives to the list of programs eligible for additional funds under Title II. The Board wholeheartedly supports this action, and also urges the Committee to add alcohol rehabilitation as H.R. 4567 does.

S.2166 would maintain the current approach of Title II; that is, it would authorize specific appropriations for individual programs. The amounts authorized for FY 1985 would represent significant increases over FY 1984, and further increases would be authorized for the next three fiscal years. The bill's intent is to authorize enough funds to permit Indians to achieve a health status equal to that of other Americans - which was the original goal of the Act.

H.R. 4567, the House bill to reauthorize the Act, would significantly change the approach of Title II. Instead of authorizing specific amounts for individual programs, the new Title II would authorize one overall appropriation based on the amount required to raise all tribes to at least Level II on the Indian Health Service Priority System. The amounts allocated to particular program categories would apparently depend on actual tribal needs, with the neediest tribes having the highest priority. To assist in the authorization and distribution of funds, IHS would be required to identify each tribe's deficiency level on the priority system and the funds necessary to raise these tribes to Level II, Level I, and the zero level.

The Board supports the concept of needs-based authorization and allocation of funds. However, we have several concerns about this approach as expressed in H.R. 4567. First, H.R. 4567 replaces the goal of equal health care with the much more modest goal of Level II on the priority system. Although H.R. 4567 does not state the amounts authorized in terms of dollars, we understand that these amounts would be considerably less than those authorized by S. 2166. We do not think H.R. 4567's abandonment of the goal of equality can be justified, and support the appropriation levels in S. 2166. If the final bill were to express the amounts appropriated in terms of priority levels rather than dollars, the priority level should be the zero level, or at least Level I.

Second, we are concerned that H.R. 4567 authorizes a lump sum appropriation for all programs covered by Title II, and would permit IHS to determine tribal needs in the same way, that is, on an overall basis rather than a program-by-program basis. We are concerned that this would permit IHS to shortchange particular programs in the allocation process, particularly programs such as CHR's that it would like to eliminate. Under the House system, it would be more difficult for Congress to monitor IHS' use of funds appropriated under the Act and to require IHS to add funds for a particular program. If H.R. 4567's "needs-based" approach is adopted, IHS should be required to identify tribal priority levels for each program, and appropriations should be made separately for each program.

Third, we are concerned over the methodology IHS will use to figure tribal priority levels. Originally, IHS determinations of deficiency levels on the Indian Health Service Priority System, were based on "tribal specific health plans". Now, however, IHS has virtually abandoned the tribal planning process and although deficiency levels are supposedly redetermined each year, we are informed that the accuracy of the process has suffered considerably. If H.R. 4567's approach is adopted in the final version of the bill, we urge that the bill be amended to afford tribes the opportunity to both participate in and approve the determinations of need under the priority system.

Reauthorization of Title III, Health facilities and sanitation

IHS has repeatedly attempted to reduce or eliminate appropriations for sanitation facilities and pass primary responsibility for these facilities to other agencies. We suggest that S. 2166 be amended to provide, as does H.R. 4567, that provision of the necessary sanitation facilities and services is the primary responsibility of IHS.

Reauthorization of Title V, Urban health services

S. 2166 would reauthorize Title V of the Indian Health Care Improvement Act, which created health programs for urban Indians. The administration wants to eliminate the urban health programs, claiming that IHS' primary responsibility should be to Indians living on or near reservations, and that in any event urban Indians can obtain the same services from other sources.

We could not disagree more strongly with the Administration's position. We refer the Committee to our testimony on H.R. 4567 for a detailed explanation of our views on the importance of urban health programs.

S. 2166 authorizes enough funds to expand urban health programs significantly. However, H.R. 4567 only authorizes very small increases, which we doubt would even cover inflation. Urban health programs have been chronically underfunded, and we urge the Senate Committee to insist on its authorization levels.

Clinical care priorities.

The Board strongly supports the intent of Section 705 of S. 2166, which would prohibit IHS from implementing its proposed clinical care priorities system and require it to report to Congresss concerning the effects this system would have had if implemented during the past four fiscal years. Under the proposed system, clinical health services would be divided into four categories, with Category A having the highest priority and Category D the lowest. In the report prepared by the IHS task force on contract care, IHS acknowledged that its resources would be insufficient to fund any services in Category D, which includes kidney dialysis, intensive care for infants, and long-term rehabilitation related to substance abuse. Category C, the next lowest priority group, includes treatment for acute conditions related to alcohol and diabetes, as well as for cardiac problems and obstetrical emergencies, to name only a few. The report does not analyze whether IHS resources would permit treatment of most, some, or very few of these illnesses.

It may well be that IHS resources will be insufficient to permit treatment of certain illnesses. However, priorities should not be established on a nationwide basis in complete disregard of local conditions and tribal preference. Nor should priorities be established in ignorance of how health care would be affected. Section 705 of S. 2166 would prevent IHS from taking such action.

We do suggest one amendment to proposed Section 710(b). As written, this section would prevent IHS from modifying its provision of clinical care services in any way. IHS claims that this would prevent it from using a "decentralized community-based, decision-making process" to establish "local clinical priorities based on local needs." (See Statement of Dr. Robert Graham, HRSA Administrator, presented to the Senate Select Committee on Indian Affairs, February 19, 1984.) It is ironic that IHS would object on this ground because its proposed priority system is the oposite of the "community-based" system it describes. But in any case, we agree that IHS should not be prevented from adjusting clinical care priorities with tribal participation and approval as warranted by local conditions. Proposed Section 710(b) should be amended to make this clear.

Proposed Title VIII, Organizational improvements

The Board fully supports Title VIII of S. 2166 insofar as it would create the position of Assistant Secretary for Indian Health. This should go a long way toward solving the management problems that have plagued IHS. First, the IHS director is too far down in the agency hierarchy to have a strong voice in budget and policy decisions. All too often, these decisions are left to those whose primary interest is not Indian health and who do not understand the unique problems in the Indian health field. This results in ill-advised policies that are completely unworkable in Indian country and that are frequently overruled - but not before causing substantial disruption at the tribal level. Also, the IHS Director must contend with several layers of bureaucracy in getting clearance for release of information, which results in substantial delays in responding to questions posed by Congressional committees, performing studies and making reports required by statute, and the like.

Second, two of the most important functions related to Indian health - personnel and procurement - are in the hands of government officials who are not even in the same chain of command with the IHS director. Once again, this results in ill-advised decisions and substantial delays. We suggest that proposed Section 810(b)(2) be amended to provide that the Assistant Secretary for Indian Health would be responsible for personnel and procurement.

The Board supports the concept of an Indian Health Advisory Board because it would provide the Indian people with an official voice on health policy on both the local and national level. However, we do not agree that the members should be appointed by the President, because such a politicized Board would be inclined to agree with Administration policy. Nor do we believe that a strictly national board would be able to provide effective evaluation or assistance on the local level.

Therefore, we suggest that proposed Section 802 be amended to establish health boards at both the area and national levels. Tribal governing bodies would elect or appoint representatives to serve on the area level boards, and the area boards would each select two representatives to serve on the national board. The area level boards would evaluate local programs and provide advice and technical assistance on the local and area levels. They would also report to the national board on the particular problems in their areas. These reports would assist the national board in advising the Secretary on administrative and funding matters (Section 801(b)(1)) and preparing its annual report to Congress (Section 801 (b)(5).

Proposed Title IX, Payment for health care

Title IX is intended to solve the difficult problem of disputes between states and IHS over who is ultimately responsible to pay for Indian health care. The dispute usually arises in the context of an Indian who needs emergency services and cannot reach an IHS facility in time, or who needs services IHS cannot provide. In Montana, most Indians reside in counties where the county government finances a medical assistance program through property taxes. In such situations, IHS and the counties have not been able to agree on who is responsible to pay for the care provided to Indians, who do not pay the taxes. Of course, the Indian patients are caught in the middle.

Proposed Title IX would require IHS to reimburse states and counties for health services provided to Indians. This proposal has been criticized because it would permit states and counties to evade completely their responsibility to provide services to their Indian citizens, and also because it would commit IHS to an open-ended reimbursement obligation.

Indians, like other citizens, are entitled to services from the states and counties where they live. However, the history of the dispute between the Montana counties and IHS leads us to conclude that Montana and its constituent counties will not provide health services to Indians unless forced to do so by federal legislation or unless they receive federal assistance.

Competitive bidding, (Section 708)

The Board is very concerned about the rigid application of federal competitive bidding requirements to IHS procurement of health services. Although many services have not yet been put up for bid, IHS has been instructed to step up the process. In Montana, competitive bidding could result in award of contracts to hospitals far from reservations, which in turn would force reservation hospitals to lose because so much of their business comes from IHS patients. It would also discourage private physicians from providing contract services to Indians because of the paperwork associated with making a bid. In its testimony before this committee, the American Medical Association singled out Montana as an area where competitive bidding "is likely to reduce health facility and physician resources accessible by both the Indian and non-Indian population..."

Therefore, the Board supports Section 708 of S. 2166 insofar as it seeks to exempt IHS from competitive bidding requirements where such requirements would be detrimental to the provision of health care. However, section 708 is too narrowly drafted to achieve this result. The harm caused by competitive bidding is not solely due to the distances patients might be forced to travel. And, although distance is an important factor, no single distance can be selected that is appropriate as a cut-off point for all situations.

Therefore, we suggest that this section be amended to provide that the Secretary may negotiate a contract for health services if, in the opinion of the chief medical officer, competitive procurement would adversely affect the accessibility, quality, or continuity of health services or if the health of any Indian to be served would be adversely affected; or if, in the opinion of the responsible contracting officer, there is no substantial possibility that competition would result or that significant savings would be realized.

Catastrophic health emergency fund

H.R. 4567 would establish a $15 million Catastrophic Health Emergency Fund. The Board supports this provison and urges this committee to adopt a similar provision. We refer the Committee to our comments on H.R. 4567 for a full expression of our views.

We thank the Committee for its careful consideration of our comments.

Respectfully submitted,

MONTANA INTER-TRIBAL POLICY BOARD

/s/ Caleb Shields

By: Caleb Shields, Chairman

cc: House Interior and Insular Affairs Committee

Mr. **Taylor**. I would like to call the following group as a panel: Antoinette Hagener, Hill County Commissioner from Havre, MT; Carol Graham, president of the Montana County Welfare Directors Association in Hamilton, MT; and Jim Halverson, Roosevelt County Commissioner of Wolf Point, MT, if Jim is here. Is Jim Halverson here?

Ms. **Hagener**. He is not here.

Mr. **Taylor**. Thank you, please proceed, Ms. Hagener.

STATEMENT OF ANTOINETTE HAGENER, HILL COUNTY COMMISSIONER, HAVRE, MT

Ms. **Hagener**. Mr. Chairman and members of the committee, I am Toni Hagener, county commissioner from Hill County, Havre, MT. I thank you for the opportunity of speaking before you today, and I appreciate your courtesy and attention in listening to this lengthy testimony.

I represent those counties within the State of Montana having Indian reservations within their borders or located adjacent to them. I have submitted a resolution supporting my testimony today and will not read it. Nevertheless, it indicates 15 counties that are involved.

As county commissioners and as caring individuals—and let me emphasize that—we are concerned about the health care needs of all of the medically indigent individuals in our country as well as those medically indigent persons who are enrolled tribal members.

We feel that it is most important that the legislation proposed and before you today be passed and that sufficient funding be provided to cover the cost of reimbursement to counties and local health facilities for the cost of treatment of those medically indigent persons who are enrolled tribal members.

The Federal Government, acting through the Indian Health Service, has a longstanding obligation to provide medical care to the members of Indian tribes and should continue to be the primary funding resource, first, for the convenience in time and travel to the applying individuals who may have to come some distance in order to go through the procedure; second, to provide consistency in handling applicants since methods used by the various agencies may be different; and, lastly, because counties have limited sources of revenue to provide for indigent health care costs.

Counties are very limited by statutory mill levy regulations as well as by other budgetary concerns. We do not have an unlimited resource.

To deny both the obligation and the standing past practices of the IHS to be the primary funding resource is an abrogation of the Federal Government's obligation to the Indian and a denial of the intent of Congress in funding Indian Health Services. Alteration in past obligations and practices leaves both the indigent in need of health care and the county medical programs with no assurance of how needed medical care will be taken care of and with an administrative nightmare of applications and lengthy litigation to settle payments.

It is unconscionable that the Indian person, already sick, already poor, and in the least position to seek needed help, must be endlessly batted back and forth between agencies to find assistance. The Snyder Act, the Indian Health Improvement Act, also the Johnson-O'Malley Act, clearly reflect the congressional intent to require provision of such medical care under the general trust responsibilities of the U.S. Government.

Any change in policy which shifts costs or responsibility is certainly not consonant with the express aim of Congress to, at a minimum, conserve and improve Indian health.

A clear statement of the congressional policy intent was submitted in written testimony by Marjorie Lynch, at that time Undersecretary of the Department of HEW, in February 1976, and I quote:

> The Indian Health Service within this department has primary responsibility for providing health care services to Federally recognized Indians and Alaskan natives.

Such statements from the parent of IHS undoubtedly led to the declaration of findings and policies of the IHS Act found in 1601 and 1602 which further confirms the responsibility of the Federal Government. Even further confirmation of this obligation can be found in the *White* v. *Califano* case, 437 Supra, p. 554 and 557, wherein the court indicated that "repeatedly IHS was represented as an agency that had primary responsibility to provide comprehensive health service."

Any regulation suggesting dependence upon alternate resources is inconsistent with the congressional purpose and intent.

Funding for the treatment of all medically indigent individuals within a county is derived primarily from revenues derived from taxes imposed on property on county tax rolls. Indian trust lands are exempt from county taxes and consequently not included on county tax rolls.

Reductions in the funding of the Indian Health Service resulting in the shifting of costs of the treatment of medically indigent persons who are enrolled tribal members adds to the county's burden of payment for treatment. This burden, in some counties, may amount to the majority of all indigents treated at health care facilities. Without adequate reimbursement from the IHS, that burden may become heavy indeed. In fact, it can bankrupt county welfare resources.

The adopted policy of the National Association of Counties states that all Federal health care programs must be adequately funded. Those costs should not be shifted to county government.

Concern for indigent health care is the top priority health care issue facing counties today. Counties and health facilities must receive adequate reimbursement from the Federal Government for the cost incurred in treating medically indigent people regardless of whether they be Indians or non-Indians.

Federal programs to compensate counties and local health care facilities for the treatment of the medically indigent currently do not provide sufficient reimbursement for the increased demands for service.

We, therefore, most respectfully request your favorable action to correct the inadequacy of Federal reimbursement to counties and local health facilities for the treatment of those medically indigent persons who are enrolled members of Indian tribes.

Mr. **Taylor**. Thank you. The resolution you submitted will be made a part of the record at this point.

[The resolution follows:]

RESOLUTION OF THE INDIAN COUNTIES COMMITTEE OF THE MONTANA ASSOCIATION OF COUNTIES

Whereas, It is NACo policy that all federal health care programs must be adequately funded and must not increase the burden on the local tax base for funding purposes, and;

Whereas, NACo declares the issue of indigent health care costs to be a top priority health care issue facing counties today, and;

Whereas, counties and health facilities must receive adequate reimbursement from the federal government for the higher costs incurred in treating the medically indigent, regardless of whether they may be Indians or non-Indian individuals, and;

Whereas, reductions in funding of the Indian Health Service have added to the burden of payment for the treatment of medically indigent individuals who are enrolled members of Indian tribes, and;

Whereas, as a direct result of reductions in funding of the Indian Health Service, medically indigent individuals who are enrolled members of Indian tribes often represent the majority of all indigents treated in health care facilities that are located in counties with reservations or adjoining reservations, and;

Whereas, federal programs to compensate counties and health facilities for treatment of the medically indigent currently do not provide sufficient reimbursement for the increased demands for services, and;

Whereas, treatment of the medically indigent is financially supported primarily by revenues derived from taxes imposed on property on county tax rolls, and;

Whereas, Indian trust lands are exempt from county property taxes and are not included on county tax rolls, but from which come medically indigent enrolled tribal members who demand treatment at county and local health facility expense;

Now, therefore, be it resolved, That NACo asks Congress to correct the inadequate federal reimbursement to counties and local health facilities for treatment of medically indigent individuals who are enrolled members of Indian tribes, and;

Be it also resolved, That NACo calls on the President and the Congress to increase funding of the Indian Health Service programs to provide adequate health care for enrolled members of Indian tribes who are medically indigent.

Approved this 15th day of February, 1985.

Editor's note.—The above resolution was signed by Commissioners from the following counties: Big Horn, Chouteau, Flathead, Hill, Phillips, Rosebud, Roosevelt, Valley, Blaine, Daniels, Glacier, Lake, Pondera, Sanders, and Sheridan.]

Mr. **Taylor**. Ms. Graham.

STATEMENT OF CAROLE GRAHAM, PRESIDENT, MONTANA COUNTY WELFARE DIRECTORS ASSOCIATION

Ms. **Graham**. Thank you. I am Carole Graham, president of the Montana County Welfare Director's Association. I also bring support from the National Council of Local Administrators of the American Public Welfare Association. Also, there will be a support letter from the Montana Department of Social Rehabilitation Services.[1]

The Montana County Welfare Director's Association requests the opportunity to clarify our position on an issue, one which has significance to all local governments concerned with the health care of American Indians residing on reservations created by Federal treaties. The Indian Health Care Amendments of 1984 which was S. 2166, was passed by both Houses of Congress but vetoed by President Reagan.

A principal justification for the veto, according to the President's message, revolved around an amendment which established a demonstration project within the State of Montana. This provision would have prohibited the Indian Health Service from considering an indigent Indian's eligibility for State and local health care programs funded by property taxes. In other words, with passage of this amendment, Federal responsibility for Indian health care would be ensured with no burden imposed on local, nontribal property owners.

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[1] Not received at time of printing.

The provision came about as a result of contentions from Montana county welfare officials that Indians who did not pay property taxes were receiving benefits from local tax-funded medical programs. They point out that the federally financed Indian Health Service, rather than the local health programs, should be the primary provider of care to indigent Indians in their State.

The admission of a Federal obligation to Indian health care has been ordered in numerous court cases over the years. Until budgeting constraints became paramount, the Indian Health Service paid all costs in Montana, ignoring laws which had been on the books since 1920 allowing them to charge local governments for Indian health care. Only in recent years have Montana local government entities been expected to pick up the tab for Indian health care.

Indian health care has had a long-standing policy which has been disputed in courts known as the "residual resource rule" in which the agency pays for care in non-Indian Health Service facilities with contract care funds only after all third party sources of payment have been exhausted.

The Indian Health Service alternate resource rule seems inconsistent with Federal statutes and congressional intent. The Snyder Act and the Indian Health Care Improvement Act were passed by Congress and upheld by Federal courts to entitle Indian persons to contract health care provided by Indian Health Service. The Johnson-O'Malley Act, 25 U.S.C. 452, also illustrates Congress' intent that the Indian Health Service be the primary resource and provider of health care for Indian persons.

Defenders of the administration's position counter these points first, by indicating that the cost would be too great and, second, by arguing that Montana Indians as Montana citizens have a right to maintain their eligibility for State and local programs.

The issue of discrimination against counties who consider Indian Health Service the primary resource is invalid. The policy of determining a person's eligibility for benefits is based on the financial ability and resources of those persons. The policy of the county is not based on race. Rather, the county has taken the position that because persons are eligible for Indian Health Service medical care, they are not in need and do not qualify for county medical assistance. No distinction is made between persons who may qualify for Indian Health Service care, Medicaid, Medicare, or have private insurance. Such a classification based on financial resources is certainly not discriminatory.

Several Montana tribes back the Montana demonstration program and support its inclusion in an Indian Health care bill. They feel that Indian health care is an entitlement based on treaty law and that the federal government should therefore be the primary provider of care for Montana Indians.

At our Montana meeting, some of the directors made the following observations: One, the BIA is responsible to provide general assistance to all registered Indians and general assistance means providing the basic needs of life which includes medical needs; two, Indian Health Service has been the primary provider for years, but now that money is tight, they are looking to county entities; three, Indians consider the Indian Health Service to be the responsible agency for their health care; four, coming to the welfare office for an Indian is not socially accepted by his or her peers. Associating Indian health care with the welfare office is offensive, particularly since well-to-do Indians receive their benefits at the Indian office while the poor must go to the welfare office; and five, the Indian Health Service has not been consistent in its use of the alternate resource rule. There is wide variation between counties in the type of Indian referrals made to the medical offices.

Montana's Roosevelt and Hill Counties have entire Indian reservations within their borders. With the reservation being tax exempt lands, these counties have limited tax base to raise the mills needed to finance the local welfare programs. Also, the State limits the number of mills a county may levy to fund their welfare program.

The Montana County Welfare Director's Association requests that the Select Committee on Indian Affairs support the premise that the Indian Health Service is the primary health resource for indigent Indians and that the responsibility for their health care should not be passed on to local and State government.

Thank you.

Mr. TAYLOR. The correspondence you submitted will be included in the record at this point.

[The correspondence follows:]

NATIONAL COUNCIL OF LOCAL
PUBLIC WELFARE ADMINISTRATORS
OF THE AMERICAN PUBLIC WELFARE ASSOCIATION
1125 FIFTEENTH STREET, N.W. WASHINGTON, D.C. 20005

Suite 300
Telephone: (202) 293-7550

March 1, 1985

RECEIVED [illegible] 1985

Senator Mark Andrews
Chairman
Select Committee on Indian Affairs
838 Senate Hart Building
Washington, D.C. 20510

Dear Mr. Chairman:

On behalf of the National Council of Local Public Welfare Administrators (NCLPWA), an affiliate of the American Public Welfare Association, I would like to convey to you our support for S. 277, the Indian Health Care Amendments of 1985. Passage of these amendments is necessary to ensure that the medical needs of indigent Indians continue to be met.

In addition, however, the NCLPWA would like to urge your support for an amendment which would clearly establish the federal government as the primary rather than the residual provider of health care for American Indians. Treaties, federal statutes, congressional intent and judicial decisions all recognize the federal trust responsibility to American Indians. The Indian Health Service by applying the residual resource rule and expecting counties to pay the costs of health care for indigent Indians, is unfairly abrogating its federal trust responsibility to Indians. Further, since Indian reservations are tax exempt counties with reservations within their boundaries have a greatly limited tax base from which to finance necessary health care for indigent American Indians.

The NCLPWA meeting in Washington on February 14 endorsed the position of the Montana County Directors' Association and authorized its president, Carole A. Graham, to testify at the March 6, 1985 hearings on behalf of the National Council of Local Public Welfare Administrators as well.

Thank you in advance for your consideration of our views.

Sincerely,

Peter A. Breen

Peter A. Breen, Chair
National Council of Local Public Welfare Administrato
and
Director, Marin County Department of Health
and Human Services

cc. Senator John Melcher

Mr. TAYLOR. I have a couple of questions.

Ms. Hagener, first of all, you gave a citation to a case out in California and I did not get that down correctly.

Ms. HAGENER. It is *White* v. *Califano*.

Mr. TAYLOR. I am familiar with that case.

I would just like to make a couple of general observations about this problem. It may well be the denial of medical services today is not one that is based on race. In the past, it was. Until 1950, Indians could not vote in the State of Arizona because they were considered to be citizens of a tribe. They did not pay taxes and, therefore, were not citizens of that State.

It took a Federal law suit to correct that situation.

My understanding is that in Montana, until about 1965, there was State legislation, referred to as the "Ward Indian Act" that apparently precluded the State or county governments from paying certain welfare costs and health costs for Indians. The background history is one that does smack of racism.

I do not believe that that is the current situation. I think we have come a long way.

The concern here that is being manifested is that this may be a regressive step. We have a conflicting philosophy. There is a trust responsibility, in my personal opinion. The President does not share that. I do not know whether the Congress does, but I agree with Senator Melcher. There is a trust responsibility to provide health care to Indians.

There is also a 14th amendment responsibility of States to treat Indians as equal citizens of their State and to provide services on a nondiscriminatory basis.

It seems to me that what we have is a conflict in these two philosophies and a question of who is going to bear the financial responsibility. I do not think it is a sufficient answer, really, for the Federal Government to push the entire thing off with total blinders on about the financial stability of local governments. By the same token, we have this 14th amendment question, and for the State to push the entire thing off on the Federal Government really leads us into a conflict with regard to the services.

Frankly, I think Mr. Shields put his finger on the problem. I think Senator Melcher has raised a legitimate issue. It has been raised in the State of South Dakota also. It warrants a good hard look, and perhaps some study is a way out of the problem that we are in right now.

These are my personal thoughts. They do not represent those of any Senator or the Senate, but I felt compelled to express them.

I do appreciate your testimony, and I am sure we will be hearing more from the Senators as they think about these issues. Thank you very much.

We do have two witnesses that did not appear on the witness list. Burnett Whiteplume of Wind River, WY, and Allen Slickpoo from Nez Perce.

STATEMENT OF BURNETT WHITEPLUME, COCHAIRMAN, NORTHERN ARAPAHOE BUSINESS COUNCIL, WIND RIVER RESERVATION, WY

Mr. WHITEPLUME. Good afternoon. My name is Burnett Whiteplume. I am the cochairman of the Northern Arapahoe Business Council which is the tribal council from Wind River Indian Reservation in Wyoming. On the reservation, we have two tribes, the Shoshone and the Arapahoe. I am here to make my comments on S. 277, and I will try to keep my comments short because it has been a long afternoon.

On title I, I think it is way past due that we see that the CHR Program will be included as part of the Indian Health Service overall program.

The other issue that is not addressed at this time in S. 277 is the health plans that the U.S. Government spent a lot of money on a few years ago. I can remember when we had to develop our tribal-specific health plans, but it seems that we have a plan developed but we have no implementation of those plans.

The case in point here is we lost two positions this year. Because of construction of hospitals in other areas, they have to take, I believe, eight positions away from the Billings area. We took two of those positions as a loss at Wind River. We are included in the Billings area. I think in the future we should have a Wyoming area because we are in those big wide open spaces, and I think people forget that we are out there sometimes.

On the budget, if we did implement our plans, the service unit plans and the tribal specific health plans, I think the budget would be demanding more money. In other words, we have plans and those plans take money to operate. The Government spent a lot of money developing those plans and the tribes spent a lot of time trying to comply with plans, but they are just on the shelf. I think if the program is to operate, and that is what the intent was in developing these plans, I think in the budget we are way overboard. I do not see that as a reason just to leave those.

What has happened here I think is the budget, because we need so much money, that those plans were just shoved aside.

On the reorganization, I think it is about time to because the Indian Health Service needs to make some decisions that are important, that need to be made within a certain timeframe. We are happy to see that the reorganization of the Indian Health Service under the Assistant Secretary is being proposed.

I will close my comments here at this time unless you have any further questions.

[The prepared statement follows:]

PREPARED STATEMENT OF BURNETT WHITEPLUME ON BEHALF OF THE MEMBERSHIP OF THE SHOSHONE AND ARAPAHOE TRIBES OF THE WIND RIVER RESERVATION, WY

We support the continuation of existing P.L. 94-437 programs that are provided for in S. 277. We are pleased with provisions in S. 277 that would extend most of the existing authorities of P.L. 94-437 for another four years. Although significant improvements have been made in Indian health care as a result of the Act, the general health status of our people remains unacceptably low. Because of this, reauthorization of P.L. 94-437 is especially important at this time; without it more people will suffer from the adverse health problems that led to the enactment of the bill in the first place.

We are especially concerned about the Administration's ongoing attempt to eliminate the Community Health Representatives (CHR) Program, and Urban Indian Health services. We support the inclusion of the programs for CHR in Title I (Indian Health Manpower). This section specifically notes that the authority for funding and operating the CHR Program is derived from the Snyder Act of 1921. Similarly, we support Title V (Health Services for Urban Indians) provides for the continuation of urban Indian health projects but specifies that the authority for such projects rests with the Snyder Act of 1921.

The Congress expressed two major goals in passing P.L. 94-437 on September 30, 1976:

1. To insure that the health status of Indian people is at parity with that of the general U.S. population, and
2. To achieve the maximum participation of Indian people in Indian health programs.

We support these goals and feel that these things are happening slow but sure and we can't stop now. The proposal to zero out CHR's, Urban Indian Health and Tribal Management would only add to slowing down the above process.

Ms. ZELL. I would like to address the point you made about the tribal-specific health plans. There is money included in the authorization levels for title II in S. 277 to enable the update of those tribal-specific health plans. Then, the health resources deficiency levels, on which the Department is mandated to report to Congress, would be based on those updated tribal-specific health plans. The members of the committee share your concern that a lot of effort and energy went into the preparation of those plans, and they should not be sitting on shelves gathering dust but should be the primary indicator for the Indian Health Service and for Congress to identify the unmet health care needs of the tribes.

Mr. TAYLOR. Mr. Slickpoo?

STATEMENT OF ALLEN P. SLICKPOO, NEZ PERCE TRIBAL EXECUTIVE COMMITTEE

Mr. SLICKPOO. Thank you, Mr. Chairman and members of the committee. I appear unexpectedly, but since I am here in Washington on other matters, I would like to address the committee more or less from the consumer's point of view. I am not a provider. I am a consumer, and I feel that I speak on behalf of the consumers.

It is too bad that the consumers cannot afford to come to Washington and personally express their feelings or their concerns before the Senate and the House committees. This is why we are dependent upon the providers to come to Washington and speak on our behalf.

Nevertheless, I do strongly feel that the reservation programs should hold some consideration of priority concern. We do have on our reservation, and I do strongly feel that other reservations are not geographically the same nor is the situation the same in some of the aspects of health services that are being provided. There is a situation of understaffed clinics on our reservation, a staff that is overworked with overcrowded clients who have to come to the clinic and wait to see a doctor for long past their designated appointment time, some waiting for as much as two hours. There is a need for expansion to provide better services.

I feel that the contract care and the outpatient care should not be totally eliminated because I do not, as a consumer, feel that these services that are being provided with the existing clinics that have been authorized by the Indian Health Service are adequate to serve all the people on the reservation. Considering the fact that we are from where I live to Lapwai, ID which is the headquarters of our tribe, and where the clinic is located that I cannot, in case of an emergency, travel 60 miles at any time of the night and also call upon a doctor and say I need services right away which is of an emergency nature.

I think sometimes that the Indian Health Service becomes too stringent in its regulations in saying that we must get prior approval prior to seeing a contract doctor, especially when it is in cases of emergency. Some members of my family have been faced with this situation, not to mention many other considerations that would have to be undertaken in that respect.

I also feel that the CHR Program provides a delivery service and outreach work on the reservation which has been very fruitful.

There are many of us who cannot afford means of being transported to the clinic or to meet our appointments with doctors or other health related matters. A lot of our people are destitute and unable to be transported or unable to meet the needs that they have in seeing doctors or going to the clinic or to the hospital. In case of emergencies, they are called upon. I know for a fact that they are called upon even away from their home with 24-hour service expectations.

Service of the CHR's on our reservations are 30 miles apart, serving three populated areas, namely: Lapwai, Orofino, and Kamiah. If the services are not to be continued under the community health service program, then a lot of these people are not going to be able to be adequately served for their health needs as provided under the, you might say, inherent right that was made with the U.S. Government by which the Indian Health Service provides such services.

One of the most devastating and fearful enemies, more so than the enemy on the front line of battle, has been the chronic alcohol problem. I do feel that Congress, both the House and the Senate, should in some respect pay particular attention to the growing problem of this situation. I also feel that other programsor interest groups should be competitive with tribal health programs but we do have to remember one thing, that the treaties were made for the reservations and that emphasis should be prioritized in that respect.

Thank you.

Mr. TAYLOR. Thank you very much, Mr. Slickpoo.

That concludes our hearing for today. The hearing is adjourned.

[Whereupon, at 4:07 p.m., the hearing was adjourned.]

APPENDIX

Additional Material Received for the Record

Absentee Shawnee Tribe of Oklahoma
Post Office Box 1747
Shawnee, Oklahoma 74801
Phone 275-4030

March 28, 1985

RECEIVED APR 0 3 1985

Senator Mark Andrews, Chairman
Select Committee on Indian Affairs
United States Senate
Washington, D.C. 20510

RE: S. 277, A Bill to Reauthorize the Indian Health Care Improvement Act of 1976.

Dear Senator Andrews:

Thank you for the opportunity to comment on the various parts of S. 277. The Absentee Shawnee Tribe of Oklahoma concurs with legislation to reauthorize the Indian Health Care Improvement Act of 1976. Specific comments by TITLE are as follows:

TITLE I

The Tribe supports the intent of Congress that the Community Health Representative Program be authorized under the authority of the Snyder Act. We note, however, that Section 108 of S. 277 does not contain language which states the intent of Congress that the CHR Program shall be a program contracted to the various tribes.

If the Indian Health Service is authorized to operate the program with IHS employees, we are concerned that the funds may be expended on fewer CHR employees at higher salaries, and on administrative expenses in the Area Offices and Service Units.

Section 108(b)(4) requires the Indian Health Service to develop and maintain a system that provides close supervision of Community Health Representatives. The tribes should be assured that the system does not provide for IHS employees to supervise tribal employees.

TITLE II

We assume that the funds appropriated under Section 201(h), and designated as the Indian Health Care Improvement Fund, were previously referred to as the "Equity Health Care Fund." It is the belief of this Tribe that close accountability must be required of the Indian Health Service for this type of a fund. The Oklahoma City Area Office was unable to demonstrate to the tribes in the Shawnee Service Unit where fiscal year 1982 Equity Health Care funds were allocated or expended on unmet health needs of the tribes.

The Indian Health Service has contended that no "Equity Health Care" programs can be contracted to a tribe unless contracted under P.L. 93-638 procedures. This provides that when a tribe takes over an IHS function, all affected tribes must concur. We note, however, that Section 201(d) requires that tribal specific health plans be brought current, and Section 204(b) requires a tribe to submit a comprehensive plan developed by such tribe for health promotion and disease prevention among members of such tribe.

If the Indian Health Service sustains its contention that no Indian Health Care Improvement Funds may be contracted to the tribes except under P.L. 93-638 program regulations, how can individual tribal specific health plans be revised and a comprehensive tribal plan be developed without funds? Most CHR staffs are not large enough to accomplish this. Provisions should be made in S. 277 for the Indian Health Service to use Indian Health Care Improvement Funds for contracts with tribes under Buy Indian Act procedures, or through grants.

TITLE V

The Tribe supports the intent of Congress that the health services program for urban Indians be authorized under the authority of the Synder Act. Whereas Section 502 authorizes the Secretary to enter into contracts with urban Indian organizations, we have previously pointed out that Section 108 does not mention contracts with tribes for the CHR Program. We recommend similar contract wording in Section 108 for the tribes.

TITLE VI

The Tribe supports Section 602, the establishment of the Indian Health Service as an agency of the Public Health Service.

TITLE VII

The Tribe endorses the establishment of an Office of Alcohol and Drug Abuse within the Indian Health Service under Section 706(d).

The Tribe does not endorse Section 709 which prescribes the eligibility of California Indians in several subsections. It appears that the eligibility requirements are less than those for Indians eligible for services outside of California.

We appreciate the opportunity to submit comments on this important legislation.

Sincerely,

Dan Little Axe
Governor

DLA/ds

BILL SHEFFIELD
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR

RECEIVED MAR 20 1985

March 20, 1985

The Honorable Mark Andrews
Chairman
Senate Select Committee on
Indian Affairs
SH 838 Hart Senate Office Bldg.
Washington, D.C. 20510

Dear Mr. Chairman:

This letter is being written in support of S.277, to reauthorize and amend the Indian Health Care Improvement Act, and for other purposes.

Alaska has a large population of Alaska Natives who look to the Indian Health Service for quality health care. The role of the IHS continues to be instrumental in the structure of the health delivery system and a major factor in achieving the goal of improving the health status of Alaska Natives. To help attain that goal, we fully support the provisions of Public Law 93-638 providing for contracting with Indian tribes or tribal organizations.

Toward that end, Title IV, Access to Health Services, establishes in Section 404 a "Demonstration Program for Direct Billing of Medicare, Medicaid, and other Third Party Payors." Alaska Native health organizations if selected as demonstration contractors under this provision would be authorized to directly bill and receive payment for health care services provided under medicare, medicaid or third party payor programs. The medicare and medicaid reimbursement would be 100% federal funds, and would be received and retained by the contractor.

We are concerned, however, that any medicaid receipts earned by a contractor under this title, not be charged against the proposed State medicaid cap that has been presented in the President's FY 86 budget. Contractors must realistically expect the opportunity to earn more third party receipts than the hospital or clinic earned under IHS administration. A capped medicaid program may close the door on that opportunity.

Provisions for the catastrophic health emergency fund, the continuation of the community health representative program, the emphasis on health promotion and preventive health services, the requirement for an IHS Health Facilities plan, and access to IHS facilities by otherwise non-eligible persons are essential to quality health care in Alaska. We are particulary concerned that the community health representative program be firmly established in law and that funding be ensured.

Hepatitis B has been a major health concern for all Alaskans and specifically for Alaska Natives who have been determined most at risk. The provision to address this health threat will help alleviate those concerns.

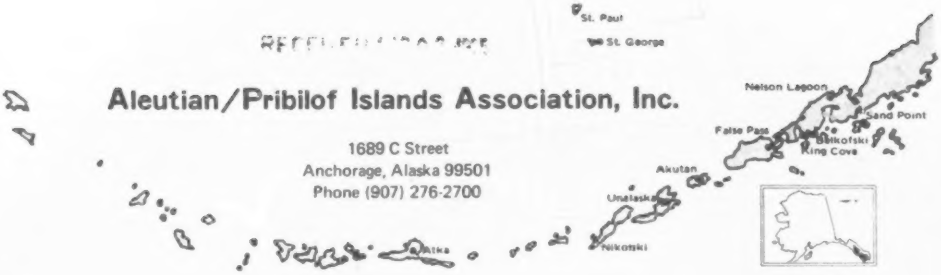
Enactment of legislation to reauthorize and amend the Indian Health Care Improvement Act will help build a responsive total health care system in Alaska and throughout the nation. I urge your favorable consideration of this legislation.

Sincerely,

Bill Sheffield

Bill Sheffield
Governor

cc: The Honorable Ted Stevens, U.S. Senate
The Honorable Frank Murkowski, U.S. Senate
The Honorable Don Young, U.S. House of Reps.
AFN



Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 276-2700

March 28, 1985

The Honorable Mark Andrews, Chairman
Senate Select Committee on Indian Affairs
Washington D.C. 20510

Dear Senator Andrews:

I am writing on behalf of the Aleutian/Pribilof Islands Association to provide written testimony in support of S.277, a bill to reauthorize the Indian Health Care Improvement Act of 1976. It has been documented that Alaska Native and American Indian people suffer the lowest health status of all Americans. In addition, these individuals are at a greater risk of contracting a number of diseases than the general population. S.277 is absolutely critical to assure the highest level of functioning of our nation's first inhabitants.

The reauthorization of this bill is especially important for the health of the Aleuts residing in eleven communities throughout the Aleutian/Pribilof Islands region of Alaska. These eleven communities are separated from one another by mountains, the North Pacific Ocean or the Bering Sea. The Coast Guard has described the weather in our region as "the worst in the world." Weather, geography, difficult transportation and communication patterns and extraordinary transportation costs severely impact the delivery of health services to our residents. S.277 contains provisions that are essential for the maintenance of a very basic, even primitive by some standards, health care delivery system.

Through a contract with the Indian Health Service, the Aleutian/Pribilof Islands Association provides primary health care and emergency medical services through the utilization of community health aides, community health representatives and emergency medical service squads. Unlike many other regions in the State of Alaska and lower 48, our region is unique in that there is no regional medical center where more sophisticated medical services are available.

Residents of the Aleutian/Pribilof Islands region must travel to Anchorage if more extensive care such as surgery or laboratory testing is required. Travel from some of our villages to Anchorage costs over one thousand dollars per round trip. Therefore, it is not only imperative that we maintain a basic level of health services in each community, but we must strive to establish community based health promotion and disease prevention services as well. S.277 provides for these programs in Titles I and II.

We are particularly anxious about the Community Health Representative program. The Indian Health Service has worked very hard during the past two years to address the concerns of the Administration and reorganize the program. The Community Health Representative program is vital to improving the health of our people. It is a cost effective way to implement preventive health services: to give attention to small problems before they turn into major life threatening crises. In our region, services aimed at health prevention are not a luxury, they are a necessity. The authority for Community Health Representative activities derives from the Snyder Act of 1921. It is an essential program that will allow the Indian Health Service to fulfill its mission to the fullest extent possible.

The last comment we would like to make is in regard to Title VII which authorizes a program to combat Hepatitis B, a condition so prevalent among Alaskan Natives. Screening, reporting and vaccinating people against Hepatitis B are essential services which must be provided if we are to improve the health status of the Alaska Native population.

Senator Andrews, we are in support of S.277 and urge the committee to assure swift passage of a bill that will survive the threat of the President's veto.

Sincerely,

Kathleen M. Sutcliffe

Kathleen M. Sutcliffe
Health Director

KMS:llm

WRITTEN STATEMENT
Of The
AMERICAN ACADEMY OF FAMILY PHYSICIANS
Submitted To the
SENATE COMMITTEE ON INDIAN AFFAIRS

RE: INDIAN HEALTH CARE AMENDEMENTS OF 1985

The American Academy of Family Physicians (AAFP) wishes to thank the committee for allowing it to present this written testimony in general support of the "Indian Health Care Amendments of 1985."

Last year in testimony supporting the reauthorization legislation, the Academy told this body of its twenty years of concern for the continuing improvement in the health status and the health care for American Indians and Alaska Natives (collectively referred to as Native Americans). Annually, representatives of the American Academy of Family Physicians and the Indian Health Service meet, visiting health facilities and discussing solutions to Indian health problems. These site visits have enabled the Academy representatives to see directly the improvements in health and health care which have resulted from the Indian Health Care Improvement Act (PL 94-437). The Academy believes, therefore, that it is necessary that this Act be reauthorized, and thus, supports these amendments which will do just that. Though much has been accomplished through PL 94-437, much remains to be done to bring the health status of Native Americans into parity with that of the general population.

The American Academy of Family Physicians supported the original Indian Health Improvement Act in the mid-1970s. In a straightforward manner, it laid out problems and the level of funding which would be authorized. In many cases, this bill does the same. However, the Academy is concerned by the ever-increasing amount of report writing required by the Congress as it pertains to Indian Health. Many of the amendments to titles II, III, V and VII have nothing to do with the actual delivery of health care services, and draw resources away from that purpose. The Academy would request the committee's reconsideration of the reporting requirements to confirm that the delivery of health care services will truly be enhanced by these provisions.

Regarding specific sections of the bill, the Academy has the following comments.

TITLE I

It is obvious that improvements in health care for Native Americans cannot be improved without adequate numbers of dedicated health professionals. PL 94-437, and its subsequent reauthorizing legislation, PL 96-537, attempted to address this situation by funding programs to recruit and prepare Native American students for the health professions. The AAFP supports the continued authorization of the Health Professions Recruitment Program for Indians (Sec. 102). In general the Academy support Section 103, but has some concern with the language of the new subsection (d) which prohibits the secretary from denying scholarship assistant to an eligible applicant solely on the basis of his or her academic standing. While academic standing may not be the only criteria for denial of assistance, it should be a major criteria. There is no reason to continue scholarship support for someone who cannot or will not maintain at least a minimal academic level.

Section 104 deals with the Health Professions Scholarship Program. No reference is made in the bill to reauthorizing this section. Instead, a new section, Section 107, Indian Health Professions Scholarships, is added. The American Academy of Family Physicians supports the reauthorization of the original Health Professions Scholarship Program. The Indian Health Scholarship Program with the National Health Service Corps Scholarship Program (Sec. 338G, Public Health Service Act) has served well in providing physicians for the IHS. Nearly three-fifths of IHS physicians are or have been obligated. Most of these physicians are not American Indians or Alaska Natives. While it is essential to increase the numbers of Native Americans in medicine, this should not be the primary goal of this legislation. Rather, the purpose is and should be to increase the number of health care providers for service to Indians. One should not expect Native Americans to be solely responsible for providing services to Native Americans. The health care of American Indians and Alaska Natives is a responsibility borne by all of society. While it is reasonable that Native American students receive preference in receiving such scholarships, it would be detrimental to the IHS and the health of Native Americans if the scholarships were limited to Native Americans.

The AAFP is concerned that Section 106, Continuing Education Allowance, is not to be reauthorized. The American Academy of Family Physicians since its inception has recognized the necessity of continuing education for maintaining the competence of health professionals. It is an integral part of their professional lives. The need for continuing education for health professionals was recognized when

PL 94-437 was enacted. However, no funds were authorized specifically for continuing education when reauthorization occurred in 1980. Rather, funds for continuing education have been made available through the hospitals' and clinics' budgetary authority. During visits to IHS facilities, a recurring complaint heard from IHS physicians, nurses, and other health care professionals is that funds provided for continuing education have been insufficient. The Subcommittee on Indian Health has been concerned that continuing professional education appears to be an expendable item. In reauthorizing this law and later in the appropriations process, Congress and the Administration must consider continuing education for health care providers as a part of providing adequate health care. Further, continuing education must be budgeted at a level to ensure access to off-site programs, especially in light of the isolation of many IHS health care professionals and the current cost of travel.

The AAFP strongly supports the new Section 108, Community Health Representative Program. The CHR program is a low technology, labor intensive, early intervention program which serves to increase access to health services. The CHR can be an effective part of the health care team in the area of health promotion and disease prevention. Provisions in this section ensure that previous problems with the CHR program are avoided in the future.

TITLE II

The Indian Health Care Improvement Act attempted to eliminate the backlog of unmet health needs among Native Americans. It authorized resources, funds and positions, in excess of existing resource levels, to address those needs. Specifically, those unmet needs are in the areas of patient care, field health, dental care, mental health and alcoholism and in the maintenance and repair of health facilities.

In reauthorizing the section of the law dealing with unmet needs, three issues should be considered. First, the intent of Congress in enacting the law was to provide funds in excess of those provided under the annual IHS appropriations bill. A report released last year by the IHS showed that less than twenty percent of the funds authorized were appropriated. For the period FY 1978 through 1980, funds were authorized for 1,533 health care staff positions but only 300 positions were actually funded. Using constant dollars, appropriations to the IHS have declined since the enactment of PL 94-437 and the backlog in health care needs has not been addressed as intended. The Academy wishes to draw the committee's attention to Section 201(b)(1) which states unequivocally that funds appropriated under this section shall be used to augment the ability of the Service to meet its health service responsibilities (emphasis added). The AAFP strongly favors this.

The type of health care problems among Native Americans is changing. Much of the IHS system has been built around acute inpatient intervention. However, in some areas, over ninety percent of the patient encounters are ambulatory visits. Thus, there is a need to upgrade outpatient services. When inpatient care is required, it is increasingly the result of an accident, or a debilitating illness. Accidents are among the leading causes of death. Diseases such as diabetes, cancer, cirrhosis, as well as those diseases associated with aging are becoming more prevalent. Medical care for these conditions drains already tight funds.

Alcoholism remains the greatest health hazard facing Native Americans. Alcoholism can be implicated as a contributing factor in four of the five major causes of death among Native Americans. The Academy's Subcommittee on Indian Health has heard Native American community leaders anguish about this problem. Funds for alcohol treatment programs must be continued to investigate the causes of alcoholism among Native Americans.

The Academy supports the language in Section 203, Competitive Procurement, which would require the Secretary to waive competitive procurement requirements if, in the judgment of an area's Chief Medican Officer, the competitive procurement would compromise the health care of Native Americans. When this issue of competitive procurement was raised last year at a meeting of representatives of the Association of American Indian Physicians, the IHS and the AAFP, there was consensus for making the determination on contracts at the local level. The Academy believes that in this case, the Chief Medical Officer, being the highest ranking physician close to the health needs, is the appropriate person to make such determinations. This is consistent with Academy policy on the low bidder concept which states:

> The AAFP believes that when this process (competitive bidding) is utilized, quality of care of patient enrollees must take precedence and be maintained, regardless of the low bidder.

TITLES III & IV

The Academy has no specific comments pertaining to Title III. In Title IV, pertaining to Medicare and Medicaid providers, the Academy would favor increasing the amount of reimbursement returned to the service unit from 50 percent to 100 percent.

TITLE V

Title V authorizes the Secretary, under provisions of the Snyder Act, to enter into contracts with urban Indian organizations. Half of the nation's 1.4 million Native Americans live in urban and rural areas outside a reservation. As with many minority groups, the health status of poor Native Americans is below that of the general population. Although no comprehensive study has been conducted on the health status of off-reservation Natives, by some indicators, their health status is worse than that of those on reservations. One of the greatest tragedies of off-reservation Native Americans is that they are almost invisible. They tend to blend with other poor groups, rather than congregate into recognizable Native American neighborhoods. In this milieu, programs must be continued which provide critically needed health care services for Native Americans in those areas where no adequate alternatives exist. The AAFP generally supports this Section of the legislation, notwithstanding the Academy's concern with the bureaucracy it fosters.

TITLE VI & VII

The American Academy of Family Physicians does not maintain a strong position pro or con on the other titles of the bill.

As the AAFP stated in its testimony last year, the IHS is at a vital juncture. The demand for its services increase, but its resources dwindle and are diverted from their primary purpose--to improve the health care of American Indians and Alaska Natives. This is a time to examine carefully the commitment of the Federal government in its provision of health care services to Native Americans. If comprehensive health care to Native Americans is a goal, it is not met when per capita expenditures continually lag behind those of the general population. Last year's statement remains true, "Chronic austerity measures only create a legacy of inferior health status."

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

The American College of Obstetricians and Gynecologists (ACOG/The College) is pleased to submit comments in support of reauthorization of the Indian Health Care Improvement Act. Our organization represents over 25,000 practicing obstetricians and gynecologists (ob/gyns) who specialize in health care for women and infants.

The College strongly supports S. 277, the Indian Health Care Amendments of 1985. We have long been concerned with provision of health care to American Indians and Alaska Natives. To address these concerns, the College established a Task Force on American Indian Affairs in the early 1970s which is comprised of Fellows in the College who have had experience in providing health care to American Indians. The Task Force, designated as a standing Committee in January 1985, includes a representative from the Nurses Association of The American College of Obstetricians and Gynecologists (NAACOG) and a liaison member from the American Academy of Pediatrics (AAP).

The ACOG Committee on American Indian Affairs, which serves in an advisory capacity to the Indian Health Service (IHS), reviews the current status of maternal and child health care in the IHS. To accomplish this, committee members observe first-hand the provision of health care to mothers and infants by visiting Indian and Alaska Native communities. Observations and recommendations of the Committee are documented in a report which is sent to the IHS after each site visit.

We also cooperate with the IHS in sponsorship of a workshop designed to meet the continuing education needs of physicians, nurses, nurse-midwives, and other health professionals caring for women and infants in IHS settings. We have sponsored five workshops in the past and are now making plans for one to be held this fall.

The College is especially proud of the ACOG Volunteers in Service to American Indians Program which we implemented in 1979. This program arranges for Fellows who are in private practice to leave their practices for one month or more and volunteer their services in IHS hospitals. These physicians have been received with great enthusiasm by health care professionals already working with the IHS. It is reported that they improve morale by alleviating staffing shortages and providing opportunity for educational exchange. To date we have placed approximately 85 physician volunteers, some who have volunteered more than once, in eight IHS Service Units located in Oklahoma, Arizona, and New Mexico.

Our testimony will focus on the importance of reauthorization of the Indian Health Care Improvement Act which will further improve standards of health care for American Indians and Alaska Natives. The testimony will also include observations from site visits to Eagle Butte and Rosebud Reservations in South Dakota and site visits to Anchorage, Bethel, and Kotzebue in Alaska. Recommendations developed by the ACOG Committee on American Indian Affairs for a regional maternal and child health program are included as they could serve as a planning model for other IHS settings.

The Congress is to be commended for passage of the Indian Health Care Improvement Act in 1976, which was designed to raise the standards of Indian health care to a level equal to the general population of the United States, and for passage of the Indian Health Care Amendments of 1983. While many improvements have been made in the eight years since the Act was implemented, much remains to be accomplished. For example, the age-adjusted mortality rate for death due to all causes is 1.1 times higher for American Indians and Alaska Natives when compared to the general population. Age-adjusted mortality rates are considerably greater than those of the general population for tuberculosis, chronic liver disease and cirrhosis, accidents, diabetes mellitus, homicide, pneumonia and influenza, and suicide. The American Indian and Alaska Native age-adjusted mortality rates are below those of the general population for chronic obstructive pulmonary disease, malignant neoplasms, and cardiovascular diseases.

Of particular concern to the obstetrician/gynecologist is infant and maternal mortality rates. Data recorded by the IHS for the years 1980 to 1982 indicate that the three year infant mortality rate for Indians and Alaska Natives dropped to the lowest point ever recorded. During this period, the infant mortality rate for Indians and Alaska Natives was 11.9 per 1,000 live births. For the first time, the infant mortality rate equalled the national rate of 11.9 per 1,000 live births recorded in 1981 for the general population. However, the postneonatal mortality rate (for the period 28 days of life to one year of age) during the same period of time was 6.5 per 1,000 live births for Indians and Alaska Natives compared to the national rate of 3.9 per 1,000 live births for the general population.

From 1980 to 1982 according to IHS statistics, the maternal death rate for Indians and Alaska Natives was 7.5 per 100,000 live births compared to 8.5 per 100,000 for the general population. Although maternal and infant mortality rates -- with the exception of postneonatal infant mortality rates -have declined in recent years, we support the provision of S. 277 that requires the Secretary of the Department of Health and Human Services to develop and implement a plan to further reduce these death rates.

Many of the health problems of American Indians and Alaska Natives are associated with geographic isolation, poor socioeconomic conditions, cultural isolation, environmental and housing deficiencies, educational and nutritional needs, and inadequate access to medical care. Reauthorization of the Indian Health Care Improvement Act will continue to address many of these problems.

Crucial to continuation of IHS programs is sustained support for recruitment and retention of Indian health manpower to assure an adequate supply of trained Indian professionals to work at IHS facilities. Title I of the Act contains four sections designed to address manpower shortages within the IHS. These include identification and recruitment of scholarship recipients, scholarships for compensatory preprofessional education, summer employment experience, and continuing education for IHS employees. Provision in the Act for recruitment and scholarship support for Indian students is important as these individuals may have fewer personal and community resources to utilize than the general population. Use of Indian health care professionals may also serve as an incentive for other Indians to seek health care. In addition, the IHS operates scholarship programs in cooperation with the National Health Service Corps (NHSC) designed to increase the number of health professionals who can serve the Indian population. We support continued cooperation between the NHSC and the IHS.

It is expected that shortages in IHS manpower will continue in light of the increased demand for health care services, growth of the Indian population, and high rate of physician turnover in the IHS. Currently, there are 35 physician vacancies in the 50 hospitals operated by the IHS. Although these vacancies represent all specialties, there is a need within the IHS for board-eligible and board-certified obstetrician/gynecologists as well as subspecialty physicians such as otorhinolaryngologists. With the termination of the military draft in 1973 and the proposed cutbacks in the National Health Service Corps program — both traditional sources of IHS manpower — continued authorization of the manpower provisions contained in Title I is essential.

The College supports the concept of tribal autonomy implemented with the passage of Public Law 93-638, the Indian Self-Determination and Education

Assistance Act, as the tribes are in the best position to determine their need for services. We support the approach to reauthorization of Title II (provision of services) and Title III (construction and renovation of health and sanitation facilities) contained in the bill, which bases authorization levels on the IHS Health Service Priority System developed from the Secretary's Plan for Indian Health submitted to Congress in 1980. This Plan was derived from tribal-specific planning where each tribe determined the level of need for services. Based on the tribal reports, tribes were assigned to one of five levels -- Level I through Level V -- with Level V requiring the greatest need for services, and Level I requiring the least need for services. The goal is to provide sufficient authorization levels to raise tribes to at least Level II of the IHS Health Service Priority System. We also support a priority system for construction and renovation of IHS hospitals, clinics, and sanitation facilities.

The College supports the addition to Title II which authorizes the Secretary of the Department of Health and Human Services to provide health promotion and disease prevention services to eligible Indian patients through the Indian Health Service. Health promotion includes cessation of tobacco smoking, reduction in the misuse of alcohol and drugs, improvement of nutrition, improvement in physical fitness, and control of stress. Disease promotion includes immunizations, control of high blood pressure, control of sexually transmittable diseases, family planning, pregnancy and infant care, fluoridation of water, and control of infectious agents. Increased emphasis on health promotion and disease prevention activities would significantly improve the overall health status of American Indians and Alaska Natives.

The College is concerned with the elimination of the Community Health Representatives program and Title V, the Urban Indian program, as proposed in the Administration's fiscal year 1986 budget. Community Health Representatives provide health and nutrition education to pregnant women and motivate them to seek prenatal care. Pregnant women remote from IHS facilities would often go without prenatal care if it were not for these home visits. Elimination of the Urban Indian program could intensify inadequate access to the current health care system. In many cases, Indians may not seek care through existing services because of prejudice and cultural barriers.

Our organization supports the expansion of authority under Title IV included in S. 277, which would authorize Medicare and Medicaid reimbursement to IHS facilities to include any health care provider or other type of facility. We recognize that the provision exempting the Secretary of Health and Human Services from the requirements of competitive bidding, also included in S. 277, may be appropriate in some circumstances. However, in those circumstances when competitive bidding is conducted by the Secretary, medical determination of appropriateness should be a criteria for contracting out health care services.

The Indian Health Service is one of the few programs in the Public Health Service that provides direct health care services. The College supports the provision which would elevate the IHS to an agency of the Public Health Service. This provision will give the problems of providing adequate health care to Indians needed visibility with the Department of Health and Human Services.

In October 1983 the College's then-Task Force on American Indian Affairs visited the Rosebud and Eagle Butte reservations in South Dakota to assess the quality of maternal and child health care in the Aberdeen area. During the visit, the Task Force met with members of the Tribal Health Boards, health professionals working in the Service Units and at contract care facilities, officials from the Aberdeen IHS Area Office and the State Health Department, as well as physicians from the University of South Dakota Department of Obstetrics and Gynecology.

Members of that Task Force were shocked by the extreme rural isolation of the Rosebud and Eagle Butte communities. To reach adequate tertiary care facilities necessitates a one to four hour drive by car. Emergency cases can be transported out by air, but airstrips at both Rosebud and Eagle Butte lack two-way communication systems and lights for night arrivals and departures. These communities are also inaccessible by air during snow storms. Rural isolation also impacts negatively on recruitment and retention of physicians.

During tours of the Rosebud and Eagle Butte Service Units, the Task Force was impressed with the dedication of the employees and the desire to provide the best possible maternal and infant health care in the face of inadequate facilities and understaffing, primarily at the Rosebud Service Unit. The administrative offices of the Rosebud facility, which were built in 1911, have been condemned but are still in use. Insect infestation and erosion from water damage were evident throughout this area.

Almost all deliveries at Rosebud are handled by two nurse-midwives. There is no obstetrician/gynecologist at the Unit. Although Eagle Butte had a physician with obstetric experience at the time of our site visit, he was soon due to retire. The University of South Dakota Department of Obstetrics and Gynecology sends a resident to Eagle Butte and Rosebud once a week to see high-risk patients and screen for high-risk pregnancies. Although the Service Unit at Eagle Butte is in much better condition than at Rosebud, there is a high incidence of high-risk pregnancies at both facilities that require transfer for delivery at tertiary care centers.

In April 1984, the College's Committee on American Indian Affairs carried out site visits to assess maternal and child health care at the Alaska Native Medical Center in Anchorage, the Yukon-Kuskokwim Delta Regional Hospital in Bethel, and the Alaska Native Hospital at Kotzebue. In summary, the Committee reported that there is an overall acute shortage of nursing personnel at the three sites. Although the Committee found the quality of care provided by the existing nursing staff to be excellent, the shortage compromises patient care and leaves little time for teaching and continuing education, particularly at the Alaska Native Medical Center (ANMC). The ANMC is the major referral and teaching hospital in Alaska. There are no major obstetrical facilities in the outlying villages.

The ANMC staff provides the majority of consulting services to the outlying facilities. The Committee found that there is a need for increased site visits and supervision from the obstetric/gynecologic-trained specialists at the ANMC to the remote facilities such as Bethel and Kotzebue. Many of these areas are not staffed with obstetrician/gynecologist-trained physicians. There is a need for better early diagnosis and management of medical problems and a need to detect potential high-risk patients who may be candidates for referral to the ANMC.

The facilities at Kotzebue and at the Alaska Native Medical Center were found to be outdated and in need of renovation if not replacement. At Kotzebue, parts of the building are sinking. There is a lack of outpatient clinic space at the ANMC. The hospital at Bethel was found to be new and well-equipped.

The Committee recognized the use of community health aides as important in the dissemination of health care in the remote areas of Alaska. By training lay personnel in basic health and medical skills, each village has immediate access to a level of care previously unattainable. Climactic conditions, distance, and sparseness of population make the roles of community health aides and public health nurses extremely important for the provision of prenatal and perinatal care. The Committee strongly recommends that additional funding be made available for increased nursing positions as well as an increase in existing salaries. Replacement of the ANMC and Kotzebue facilities is also recommended. In the absence of trained specialists permanently assigned to each facility, and in light of the limited availability of specialist site visits, continuing education should be given high priority. A copy of the ACOG Committee on American Indian Affairs "Report and Recommendations, Site Visit — Alaska Area" is attached and provides additional information on the provision of maternal and child health care in Alaska.

The College strongly supports reauthorization of the Indian Health Care Improvement Act including adoption of a comprehensive maternal and child health care regional program that would assure quality access and continuity of care for Indian and Alaska Native patients. Healthy mothers and children are essential for improving the health status of the entire Indian and Alaska Native population.

Our long involvement with the IHS has illustrated the improvements which have been realized under the Indian Health Care Improvement Act. Yet we see much which remains to be done. Under the authority of this bill, we urge the Indian Health Service to continue its focus on:

1. developing a comprehensive maternal and child health care program;
2. assuring adequate physical facilities;
3. improving transportation and communication systems; and
4. encouraging linkages to university medical schools.

We offer continued commitment to work with the IHS toward these goals.

It is the College's hope that through reauthorization of the Indian Health Care Improvement Act and continued private and public sector efforts, the health status of American Indians and Alaska Natives will soon equal that of other United States citizens.

REPORT AND RECOMMENDATIONS

Task Force on American Indian Affairs
The American College of Obstetricians and Gynecologists

Site Visit - Alaska Area
April 24-27, 1984

The Alaska Area of the IHS invited ACOG's Task Force on American Indian Affairs to do a site visit in the Area. In addition to meeting with Area officials, representatives of the State Division of Public Health, of the private referral hospital, and of the Alaska Native Health Board, task force members were asked to review three hospital facilities. Sites designated were the Alaska Native Medical Center in Anchorage, the Yukon-Kuskokwim Delta Regional Hospital in Bethel, and the Alaska Native Hospital at Kotzebue. Those making the site visits to each location are identified in Appendix A of this report.

On the evening of April 24, the ACOG group met with key Area representatives of the IHS for a briefing (see Appendix B). Wednesday, April 25 was set aside for visits to the three hospitals. The schedule for Wednesday at each site included, in addition to a tour of facilities, discussions with health care providers and planners from that location. An agenda for ANMC and one for the Bethel site visit are attached as Appendices C and D. Although because of flight schedules the time available at Kotzebue was more limited, a similar schedule was followed, including both MCH and administrative people from the Maniillaq Corporation, as well as administrative, medical and nursing personnel from the IHS facility in the discussions.

The task force had been asked to review the three hospitals with particular attention to local standards of obstetric-gynecologic care in relation to the Indian Health Manual, Part 3 Professional Services, Chapter 13 Maternal and Child Health. (See also the Outline for Site Visits, Appendix E.) The clinical importance of this kind of review was expected to enhance and dovetail with the Area program review being carried out in April, May and June.

To assist the site visitors in focusing on the clinical relationships throughout the state as well as one-to-one provision of care, each site had been asked to pull specific categories of patient charts for review. Appendix F is a listing of these categories; significant time during the site visit was allotted for individual review of cases so designated.

During the next two days, the group met with representatives of IHS and the other entities responsible for planning and providing health care (see agenda, Appendix G), and concluded its own deliberations in regard to the site visit and concerns related to the IHS in general.

Summary Comments

Most prominent among task force findings was that a shortage of nurses is a limiting factor for giving adequate care. In addition, the complement of obstetrician-gynecologists in the Anchorage referral facility is not sufficient to support an adequate schedule of consultative visits to other hospitals, such as those at Bethel and Kotzebue, doing obstetrics without obstetrician-gynecologists. Climatic conditions, distance, and sparseness of population make the roles of community health aides and public health nurses extremely important for perinatal care. The presence in each IHS hospital of a nurse-midwife or other professional capable of coordinating maternal and child health care for each patient is vital, since the field nurses and aides report to tribal corporations or state officials, rather than to the IHS.

A detailed report on the site visit to each location follows. The task force deeply appreciated the care and preparation in setting up the visits and interviews, particularly the efforts of Ms. Greenman in this regard. They were also grateful for the time health professionals, administrators and board members spent helping the visitors visitors to see and understand the system as well as is possible in a short period of tour and discussion.

Anchorage Site Visit

1. A problem that was perceived by all the individuals visiting the Alaska Native Medical Center facility was staff shortage. The facility has 170 beds; it is JCAH accredited; it has an operating budget of approximately $19 million. There are 50 critical staff positions needed. Thirty of these are in nursing. There are four obstetricians, two of which are board eligible. There is one half nurse practitioner position, and one resident in obstetrics and gynecology at the senior level. These staff provide all of the consulting services throughout the entire region, as well as providing direct patient care within the Alaska Native Medical Center.

2. There is a critical shortage of staff operating room nurses. Frequently, the staff from the operating room are required to work the night shift after working all day. Because of the staffing shortages, elective surgery cases must frequently be cancelled. This further increases the surgical backlog and lengthens hospital stays.

3. The obstetric and nursing staff team responsibilities are much greater in scope than in a general hospial. The Alaska Native Medical Center is the major referral hospital, as well as a major teaching hospital. Thus, the staff responsibilities include: (a) continuing medical education for the MD's; (b) direct patient care for obstetric deliveries, clinics and surgery; (c) maternal and child health program supervision and consultation; (d) consulation for Family Medicine (this is for direct emergency services in

outreach villages); (e) teaching of medical students (in general, there is a medical student on the service at all times, which increases staff time and responsibilities. However, the medical students' program may increase the opportunity for physician recruitment.) (f) nursing education; (g) on the job training for field nurses and allied health staff at two week intervals; (h) on the job training for physicians for one month prior to entering the field. The obstetrical staff have to train the physician who will be practicing obstetrics at the Bethel Service Unit. (This is certainly an excellent opportunity for improving health care; however, it does increase the staff OB's responsibilities and their time and effort in order to train this physician).

The overall teaching responsibilities for the referral hospital at the Alaska Native Medical Center probably account for 25% of the OB staff and nursing time. With these teaching responsibilities, therefore, it would be very prudent to have additional obstetrician- gynecologists, as well as more nursing staff.

4. None of the OB nurses are trained as operating room technicians or as circulating nurses. Therefore, personnel for the operating room, which is already understaffed, are required to come in for all cesarean sections, providing the primary operative scrub and circulating personnel. It should be noted, however, that the reason that the obstetric nurses have never been trained in these surgical activities is due to the deficiency of staff position which has persisted for many years.

The nursing supervisor is not trained in obstetrics. For example, the nursing supervisor at night cannot help cover obstetrics when two or more patients are in labor, or when there are emergency cesarean sections being performed. This is a general reflection of the shortage of staff: with the added function as a major teaching center, it is difficult to meet all of the responsibilities.

5. Regarding pediatric nursing: there is a need for four additional RN's, and one ward clerk to bring staffing to national standards. There are 52 hours of overtime per pay period. Many of the nurses are lost because of the salary differential between the Alaska Native Medical Center and the salaries in the private sector in Anchorage.

6. Another problem area with the Alaska Native Medical Center is with the hospital facility itself. The hospital was built in the 1950's as a primary tuberculosis hospital. There is inadequate space in several areas of the hospital, including obstetrics. This is particularly evident in the obstetrics clinic. There are no adequate facilities for prenatal housing. Through the excellent work of the maternal, and child health personnel, however, a care cottage with 120 beds has been established. The cost for this care cottage is $27 per day, with an overall yearly cost of $35,000. to $50,000. to house prenatal patients.

The Alaska Native Medical Center is the primary referral center for the state of Alaska. There are no major obstetrical facilities in the many villages whose populations are referred to the Center. As a result, a large number of prenatal patients require housing at the Alaska Native Medical Center while waiting delivery, cesarean section, or for complications of pregnancy.

7. The out-patient clinics are grossly inadequate. There are 10 exam rooms, with only one bathroom. As many as 70 to 80 prenatal patients may be required to be seen in one afternoon. One bathroom results in considerable problems for patients in obtaining urine samples, etc.

8. The clinics have been well arranged for maternal and child health care, with two OB clinics per week, staffed by nurse practitioners and midwives. There are high risk clinics, colposcopy clinics, general gynecology clinics, and general prenatal clinics. While the clinics are being held, active educational programs are conducted. These include WIC instruction, mental health programs and nutritional education and counseling.

In addition, there are only two (or sometimes three) nurses for the clinic, and there is a desperate need for a ward clerk. The clerks that do attend the OB clinics are under the ambulatory service; they are also responsible for handling all of the telephone calls.

9. The Maternal and Child Health program from the Alaska Native

Medical Center is excellent in concept, programmatic development, and has the potential for becoming a model for the Indian Health Service. The personnel are highly enthusiastic, creative, and supportive.

The Maternal and Child Health team includes a community health assistant, family medicine physicians, state public health nurses, a linkage system to the Alaska Native Medical Center with OB and pediatric staff, linkage with the private native health care and, in particular, with the corportions. The only problem perceived by the individuals visiting the Alaska Native Medical Center was the lack of specific designation of funding for Maternal and Child Health programs. However, the relationship between the Director of Maternal and Child Health and the area seemed appropriate. There is a common goal to improve maternal and child health care for Native Alaskan patients.

10. It was brought out during the site visit that there is some disagreement in the transfer of obstetric patients to the tertiary care facility with Level III nursery capabilities. The suggestion was made by the private obstetrician/gynecologist that there was a lack of communication and a delay in referral of obstetric patients. However, the data presented clearly did not demonstrate inadequacy of timely referral to the tertiary facility. The referral of those patients that were transferred to the tertiary facility were viewed by the obstetrician/gynecologists visiting the Alaska Native Medical Center as being timely and appropriate. Due to the tremendous expense of tertiary care facilities for

intensive care nurseries, it is the recommendation of those involved in the site visit of the Alaska Native Medical Center that the Center develop a Level II nursery, either on its own, or in affiliation with the private hospital in the community. The involvement of the neonatologist, who has expressed interest in this concept, should be sought.

11. Specific problems were delineated during the interview with the staff and while touring the facilities at the Alaska Native Medical Center. They are: (a) there is a definite perception that the reading of pap smears should be thoroughly evaluated.

This perception is well substantiated by the corresponding data. There has been a marked reduction in the number of abnormal pap smears as reported by the new group of technicians reading the smears. At the same time, there has been an increasing incidence of advanced invasive carcinoma of the cervix. These two incidences are incompatible, and it is a probable correct perception that there is underreading of the pap smears. This should be thoroughly evaluated by the obstetric staff. The problem was recognized by the senior obstetrician/gynecologist, Dr. Knight, and he should be encouraged, as well as given the opportunity to evaluate this problem further.

(b) There is a perceived need for education at all levels including M.D.'s, R.N.'s, and community health aides. The Task Force members visiting the Alaska Native Medical Center were impressed with the capabilities of the staff; however, with the shortage of staff at all levels, education becomes a lower priority. All available time must be spent on direct patient care. It is recommended that every opportunity be given for Maternal and Child Health education at all levels. This includes the LPN's, the neonatologists , pediatricians, obstetrician/gynecologists, family physicians, R.N.'s, staff, and all other personnel.

(c) The plumbing and electrical systems in the facility should be replaced.

(d) Many of the deaths are related to distance, isolation, and transportation. Indeed, additional funds as well as innovative methods of delivering health care will be required to assure the maximum quality of Maternal and Child Health care to all Native Alaskans.

(e) There is a recognized need for an ambulatory, non-acute care facility, in conjunction with the hospital, to perform many of the ambulatory surgical procedures.

(f) Because of the shortage in the number of OB beds and occupancy problems, the television room for the patients has been used for post-partum recovery beds.

(g) The laboratory does not have the capability to do microanalysis on infant blood samples.

(h) The birthing room was unavailable 70% of the time because of bed occupancy problems.

(h) Increased condensation in the cesarean section room causes periodic leaking from the ceiling during operations. There represents a possibly dangerous situation, causing contamination and spread of infection.

12. The Task Force members visiting the Alaska Native Medical Center felt that thee was a need for additional meetings amongst the nurse practitioners, R.N.'s, midwives, and obstetician/gynecologists to review patient care delivery in the clinic setting. In general, there appeared to be a need for better communication, and perhaps, supervision of the gynecological problems being handled by the family physicians in the emergency room and village setting. The Task Force members are acutely aware that communication, especially organized meetings, is difficult under the best of circumstances, and that it is probably impossible when there exists a shortage of staff at all levels. The result, however, is that patient care protocol development, chart audits, and medical care review are not conducted as often as is necessary for the long term improvement of patient care.

In overview, the shortage of staff, inadequate facilities, and space shortage are major problems for the Alaska Native Medical Center. The Task Force members visiting the Center were very impressed with the work of the senior obstetrician/gynecologist and the Director of Maternal and Child Health. The quality of care which is delivered under the adverse circumstances of travel, distance, isolation, inadequate facilities, and extreme staff shortage is highly commendable.

Bethel Site Visit

1. The facility: the new hosital has 20 beds. This replaces the old facility with approximately 50 beds. It is equipped with a laboratory, a blood bank, x ray, a pharmacy, ADR ultrasound and a Corometrics monitor. The delivery room is well equipped. The labor room which is used as a backup for excess deliveries, is less well equipped. Anethesia is not available in the delivery rooms.

The operating room is adequately equipped for Cesarean sections and emergency surgeries. The operating room, as well as the entire hospital, is very modern, well kept and clean.

The outpatient clinics appear to be adequate in size for the patient flow, although the consultation rooms are cramped. There is inadequate storage space for equipment.

Recommendations:
There are no recommendations regarding the facility itself except that the patient flow should be carefully monitored to insure that the 20 bed capacity remains adequate for the needs of the population to be served. While the outpatient departments are very active, the 20 bed inpatient component is not filled. There is some question about turning patients away from the inpatient facility. This too, should be carefully monitored.

2. The staff: there are 14 physicians, including 1 internist, 2

pediatricians, and 11 general medical officers. There is a shortage in nursing personnel.

Many of the existing personnel have been working in the Bethel area for a number of years. This allows them to have an extensive knowledge of the community and the patient needs.

One of the key staffing components is the village health aides. These aides are provided with a ten week training program, a well prepared standards manual and a limited number of pharmaceutical supplies. Each aide is assigned a village. Through telephone or short-wave radio, the aides are in communication with the hospital and their supervising physicians. Under this system, the aides are responsible for a significant portion of the health care for each community. Immediate health assessment is available in otherwise remote or inaccessible regions of the state.

The aides are generally well prepared and well received. There appears to be a fractionalization, however, between the various levels of providers, including the aides, nurse midwives and physicians.

Recommendations:

a) The relationship between and the roles of the various levels of providers should be reviewed and strengthened. Referrals from the village aides, for example, should be given serious considerations by the physicians at the hospital so that the importance of the health aides is not compromised in the community.

b) There was some question of the adequacy of pay for the health aides. Because of their extremely important role in the health care network, every effort should be made to insure that their salaries are competitive with other salaries in the area.

c) The shortages of nurses is a critical problem. It is recommended that local citizens be recruited for nurse training to alleviate the situation. It is also recommended that the nurses salaries be reviewed and upgraded if necessary.

d) There are no OB/GYN specialists in the Bethel facility. All high risk ob and repeat cesarean section patients are referred to ANMC. This leaves an average of 6 cesarean sections a year performed at Bethel, which does not seem adequate to insure continuing proficiency on the part of the staff. Without an obstetrician, the goal should be to transport all cesarean deliveries to ANMC.

It is recommended that more visits from specialized ANMC personnel be made and that the Bethel staff should immediately consult by phone with ANMC on any deviation from the norm as is done at other facilities.

A final recommendation is that continuing education, chart audits and review of medical procedures be made a high priority for

Bethel personnel.

3. Transport capabilities: while greatly improved from previous years, the transport from the outlying villages to the hospital remains a problem. Because the patient usually pays for the transport by air except in emergencies, there is a tendency not to seek care unless and until there is an acute crisis. However, each village has some form of airport, which represents a great improvement.

The transport system between Bethel and Anchorage appears, weather notwithstanding, to be adequate and markedly improved from previous years.

Recommendations:
There are no recommendations regarding the transport service except that patients should be pursuaded, both through increased financial subsidy and encouragement by the villages aides, to seek care at the hospital before crises develop.

4. General observations: it was apparent to the members of the site visit team that there was considerable uneasiness on the part of the administrative and medical personnel at the hospital regarding their relationship with the Yukon Kuskokwim Area Board and, perhaps, with the service area at large. The tension seemed to focus upon the perception that the Y-K Board did not feel that the area was being adequately served by the hospital.

Recommendations:

a) Regardless of the actual cause of the problem, it is clear that greater communication between the Board, hospital staff and community at large is necessary.

b) It is recommended that there be more careful chart documentations of patient condition, diagnosis, management, progress in labor and outcome. Many charts appeared to be sketchy or incomplete.

c) It is recommended that fetal monitoring capabilities be fully utilized for improved pregnancy outcome.

d) Skills and services for family planning need to be improved.

Kotzebue Site Visit

The Kotzebue service unit consists of about 7,000 Eskimos living on 50,000 square miles in 11 villages, all above the Arctic Circle. The Kotzebue Indian Hospital was built in 1961 and has 31 beds, with an average of 10 in hospital patients and 3 beds reserved for pre-delivery boarding. The hospital has approximately 150 deliveries per year, which is an increase of 50% over the last 2 years. There are approximately 20 transports per year to the Anchorage Native Medical Center or Providence Hospital for maternal-fetal indications. The Kotzebue out patient service sees 75-100 primary care patients per day. This incudes prenatal patients. The provider staff runs clinics in the villages as well, with one physician in the field most of the time.

The recent hiring of the Maternal and Child Health coordinator by the Maniillaq Corporation has had a positive effect on the MCH program in both service and program problem solving. The nurse midwife hired in this position is focusing her activities in the prenatal care service, patient education, high risk identification, and family planning service. In so doing, she must also effectively coordinate these program components with inpatient care being given. Our visit with the MCH coordinator and the vice president for operations of the Maniilaq Corporation focused on the complementary functions of the corporation with the Indian Health Service, particularly in the activities of the health aides. The health aides are lay health personnel with 10 weeks of formal training who do much of the prenatal care counselling, post partum and family planning follow up services in the villages. They are often the first to face medical and social crises requiring consultation and transport to the Kotzebue Hospital. The hospital physicians, however, seem to be vague about the functions of the health aids. As a result, there is little formal interaction between the physician and health aides in planning, supervision or patient care conferences.

The Kotzebue Hospital medical and nursing staff appear to be dedicated, caring and competent. However, there are critical staff shortages which are compounded by a heavy work load and a high degree of crisis care and drug compromised patients.

The following observations were made about the Kotzebue facility.

1. The hospital has a dangerous structural flaw causing a portion of the building to sink over 12 inches. Concern about a possible rupture of sewage pipes place the resolution of this problem as a high priority.

2. The labor, delivery, newborn resuscitation and postpartum areas are well organized and well kept. There are, however, no bathroom facilities in the labor and delivery area. The emergency room and out-patient clinic area are functional and well organized. (No cesarean sections are done in this facility, because no anesthesia is available.)

3. Staffing: there are four physicians assigned to the hospial, with 16 nursing positions. Six were unfilled at the time of the site visit.

4. Equipment: the absence of the fetal monitor and real time was discussed. It is our opinion that this seriously compromises the clinical program. The laboratory could not demonstrate the ability to do microanalysis on infant blood samples.

5. The MCH program: the recent hiring of the nurse midwives has resulted in apparent and encouraging improvements. However, some noteworthy problems remain. First, there are no prenatal classes available to patients because patients come to the clinic at different times throughout the week. In this population with high complication rates and infrequent prenatal care visits, prenatal classes would have a significant impact on the various preventative programs.

Second, the family planning services are inconsistent and often inadequate. The patients have difficulty in getting services or follow up. Unplanned pregnancies were frequent in the charts reviewed, with obvious misuse of birth control pills. There was a ten week waiting list for tubal ligations, with several pregnancies occuring during the interval. There does not seem to be an organized, coordinated follow up program between the various providers of family planning services.

Third, despite the good effort to identify high risk conditions on the prenatal records, there seems to be no consistent plan in management of these risks. There are inconsistencies in the management of identified high risk problems associated with consultation with the Anchorage Native Medical Center. The

Kotzebue staff attributed part of the inconsistency to the different personalities involved in the Anchorage consultation and the variable attention given to the existing Indian Health Service MCH standards by those individuals.

One of the innovative programs should be mentioned because of its effect on problem solving. Because of the difficulty in getting pregnant patients to the hospital for prenatal care and evaluation, the service unit has arranged to pay for the travel costs of the first prenatal work up, and for the delivery. This subsidization, along with the predelivery boarding facility, optimize the services in the program. The cost of transportation to the hospital ranges from $50-$200 per trip: many of the prenatal assessments are made by the health aides in the field. Home delivery rates are estimated to be approximately 10%, and have been declining sharply since the implementation of this program.

6. Consultation: there is an active communication between the OB/GYN staff at the Anchorage Native Medical Center and the Kotzebue providers. Given the difficulties in weather and availability of airplanes, high risk patients are appropriately transported to Anchorage.

The obstetricians from Anchorage visit only twice a year to review cases. This is not sufficient to insure the effective supervision of the staff, proper implementation of the MCH service or adequate management of high risk patients.

7. Chart reviews: twenty charts of complicated cases, including transports, were reviewed. The following observations were made: A) The recording and identification of high risk situations is consistently good. B) Protocols for management of high risk patients were not consistently followed. C) Physical examination data on admission to the hospital in labor was not recorded in 50% of the patients. D) There was no recognition of, or action taken, regarding discrepancies in uterine size in the prenatal charts. E) With infrequent prenatal visits combined with frequent high risk situations, gestational age assessment is difficult. A number of the charts illustrated the difficulty in managing high risk situations with unknown gestational age assessments. Frequently, inappropriate procrastination and inappropriate transport resulted from the apparent indecision. Real time sonography, with appropriate personnel training in its use, would have considerable value in these situations. F) The nursing service notes and follow up on labor and delivery patients were excellent. G) In over 50% of the charts reviewed on maternal transports, there were no summary or followup records from the hospitalization in Anchorage. H) Anecdotal comments about specific charts included the following: 1) a noted lack of physician's supervision and patient assessment in patient receiving intravenous pitocin induction, 2) a lack of record of pelvic examination prior to maternal transport, 3) a lack of pelvic exam prior to Demerol medication in a patient in labor, 4) absence of blood pressure and weight records on family planning patients receiving oral contraceptives from the hospital and field clinics.

Overall Findings

There are several general observations.

1. There is an acute shortage of nursing personnel in the three sites. It is the opinion of the Task Force that the quality of care provided by the existing nursing staff is generally excellent: however, the shortage compromises patient care and, in the Alaska Native Medical Center, teaching and continuing education.

The nurses at these facilities are considered to be a vital component in the health care of the Alaskan citizens. Their role as provider and as liaison between the patients and the physicians cannot be underestimated.

2. The implementation and use of village health aides is an important step in the dissemination of health care in the remote areas of Alaska. By training lay personnel in basic health and medical skills, each village has immediate access to a level of care previously unavailable to them. Although the physician supervision of these areas must be conducted by phone or short wave radio, the aides are able to consult with physicians and make referrals to the hospitals as appropriate.

3. There is an overall concern regarding the need for increased site visits and supervision from the obstetric-gynecologic trained specialists at the ANMC to the remote facilities such as Bethel and Kotzebue. Because many of these areas are not staffed with OB/GYN trained physicians, the consultation and monitoring provided by the ANMC is essential. Although referrals to ANMC are routinely made for

high risk Ob patients and, in general, for repeat cesarean sections, there is a need for better early diagnosis and management of problems as well as detecting potential high risk patients. The availability of fetal monitors and appropriately trained staff in rural hospitals is considered an integral part of any comprehensive OB service, and should be developed as an active component in these sites.

Chart audits and review of medical procedures would enhance the supervision of obstetric-gynecologic care provided at the remote facilities. Sketchy and incomplete charts were among the problems noted at the outlying hospitals. Inappropriate and incomplete care of high risk patients was evident in chart review.

The task force does recognize the limited personnel resources of ANMC and the difficulty in providing adequate coverage of its own facility in addition to the remote hospitals.

4. There is a marked improvement in the physical availability of patient transport. The majority of villages now have some form of airstrip, making access by airplane possible except in severely inclement weather. This development, along with the use of village health aides, represents a major step in making health care accessible to even the remote areas of the state.

It must be noted, however, that patients are generally required to pay for the transport to the hospitals from their villages except in the care of emergencies. This results in an understandable reluctance on the part of the patients to seek care until an acute crisis develops. The payment for transportation by the Kotzebue service for first prenatal visit and labor trip is a significant step in prenatal care.

5. The development of complementary MCH programs with nurse midwives, counselors, social workers and health aides must be strongly supported. In the Alaska area, this team has effectively bridged a gap in the acceptability of health care for pregnant women, newborns and family planning. As a preventative service, it effectively complements the skills and services that the high volume, crisis oriented rural hospital offers.

6. The facilities at Kotzebue and at the Alaska Native Medical Center were found to be outdated and in need of rennovation if not replacement. At Kotzebue, for example, parts of the building are sinking, causing great concern. The hospital at Bethel is new and well equipped.

7. Quality of care provided: the site teams were uniformly impressed by the quality of care provided at the various facilities. Despite limited resources and adverse conditions, the personnel at all levels are dedicated and motivated towards the best interests of the patients. Although the interaction between the different components of the health care providers, for example between the physicians and village health aides, was observed to be fragmented in at least one of the facilities, the overall commitment of all providers was considered to be excellent.

8. There is apparent inconsistency in the quality and availability of family planning services. Services were markedly improved in areas with nurse midwives/practitioners. The health aides did not appear to be able to demonstrate enough skills for a comprehensive family planning program.

Recommendations

1. The task force strongly recommends that additional funding be made available for increased nursing positions as well as an increase in existing salaries. Immediate attention to this problem is necessary in order to avoid staff burnout and further turnover among the highly qualified and experienced nurses.

2. The inadequacy of two facilities visited not only respresents a hazard to those working in the facility but compromises the quality of medical care. Replacement of the ANMC and Kotzebue facilities is strongly recommended.

3. In the absence of trained specialists permanently assigned to each facility, and in light of the limited availability of specialist site visits, continuing education should be considered a very high priority. This continuing education program should encompass all levels of personnel, and be provided on a regular basis. Incorporation of the IHS-OB/GYN standards into the education program would significantly improve communications and the consistency in consultations on the part of the rural providers and ANMC obstetricians alike.

4. Fetal monitors should be in use at all facilities doing routine deliveries. Training medical and nursing staff to properly use these monitors will be necessary.

5. An additional staff position for an OB/GYN physician is needed to fill the responsibilites of supervision of outlying hospitals and staff and to help with the heavy work load at the ANMC.

6. Where possible, rural hospitals should have MCH programs to compliment physician services which would include nurse mid-wives/practitioners and active family planning services.

7. Cesarean sections should not be performed at facilities without qualified physicians and/or operating room staff.

8. The ANMC should consider developing a level II nursery with appropriate negotiation with the community neonatologist.

9. The Alaska obstetric and MCH personnel should evaluate the quality of the pap smear cytologic services to insure that the results of these tests more accurately reflects the findings expected in this high risk population.

APPENDIX A

SITE VISIT ASSIGNMENTS

ALASKA NATIVE MEDICAL CENTER

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of Obstetricians and Gynecologists

[Appendix B-G is retained in the files of the Committee.]

AMERICAN MEDICAL ASSOCIATION

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JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

RECEIVED [illegible]

March 7, 1985

The Honorable Mark Andrews
Chairman
Senate Select Committee on Indian Affairs
United States Senate
Washington, D.C. 20510

RE: S. 277, the Indian Health Care Amendments of 1985

Dear Senator Andrews:

The American Medical Association takes this opportunity to express its strong support for S. 277, the Indian Health Care Amendments of 1985.

Enactment of S. 277 is essential if valuable health care services are to continue to be made available to American Indians and Alaska Natives. In the last Congress, the AMA supported S. 2166 and its House companion bill, H.R. 4567, during Congressional consideration, twice testifying in support at public hearings. We submitted a letter to President Reagan in October urging him to sign S. 2166.

The American Medical Association strongly supports the Indian Health Service, which is the primary medical service program for Indians. The IHS can claim numerous successes. Infant mortality has been reduced from 62.5 per thousand to less than 15. Life expectancy at birth has substantially increased. Deaths from childhood illnesses, deaths at childbirth, tuberculosis, pneumonia, gastroenteritis, and many other treatable or preventable conditions have also fallen significantly for Indians. There has been a leveling off of hospitalization and a continuing increase in clinic visits, indicating less severe illnesses and fewer people requiring prolonged hospital stays. These improved statistics indicate the excellent work that the Indian Health Service is doing.

Despite the program's past successes, the health status of American Indians still remains behind that of the general population. Indians continue to have a shorter life expectancy than other Americans, and rates of infant and childhood deaths, fatalities from flu, pneumonia and tuberculosis, and hearing loss from ear infections continue to exceed national norms. The doctor-to-population ratio for native Americans is half the overall rate for the nation and many IHS nursing positions are unfilled.

S. 277 contains a highly commendable provision (sec. 203) which provides for waiver of competitive procurement requirements when such procurement would compromise the accessibility, quality and continuity of health services. The American Medical Association believes this provision of the bill is essential in order for the Indian Health Service to pursue its mission of providing Indians with the highest possible health status.

Section 601 of the bill would establish the Indian Health Service as an agency of the Public Health Service with the Director reporting to the Secretary of Health and Human Services through the Assistant Secretary for Health of that Department. The American Medical Association supports this provision. In our view, the Indian Health Service deserves an important level of priority in HHS. The Indian Health Service should remain within the Public Health Service to maintain the health-orientation of the program by keeping it under the direction of the Assistant Secretary for Health.

The statutory mission of the Indian Health Service is to permit the health status of Indians to be raised to the highest possible level. The accomplishment of that mission requires the speedy passage and enactment of S. 277. We look forward to working with you and the other cosponsors of S. 277 to help achieve this goal.

Sincerely,

James H. Sammons, M.D.

JHS/ss
1760p

PREPARED STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION

PREFACE

The American Optometric Association appreciates the opportunity to present its views on the reauthorization of the Indian Health Care Improvement Act.

The American Optometric Association supports the Indian Health Service in its mission of health care delivery to the Indian population. In addition, the AOA is generally supportive of the provisions and concepts embodied within S. 277. Yet there is one area - eye and vision care - which we feel deserves the particular attention of S.277. It is this important aspect of Indian health care to which we will focus our attention in the following statement.

INTRODUCTORY REMARKS

The American Optometric Association is a professional society representing some 24,000 doctors of optometry, optometry students and educators across the nation. As an organization devoted to improving the vision care and health of the public, the American Optometric Association promotes the art and science of optometry wherever it is practiced.

A Doctor of Optometry is a health care professional who is specifically educated and licensed in each state to examine, diagnose and treat conditions of the vision system. Otpometrists examine the eyes and related structures to determine the presence of vision problems, eye disease and other abnormalities. Through advanced technology and clinical training, optometrists may detect diabetes, hypertension, arteriosclerosis and other diseases of the body as well as primary ocular conditions such as glaucoma and cataract, which require referral to other health care practitioners for treatment.

OPTOMETRY, THE INDIAN HEALTH SERVICE AND INDIAN VISION NEEDS

It is a fact that a greater incidence of common vision conditions have been recorded in the Indian population than in the general U.S. population.

In a January 1975 study titled "Vision Abnormalities of Indian School Children: The Lame Deer Study", Dr. James. E. Hamilton, a Commissioned Corps IHS optometrist, documented this fact. His study measured the occurance of vision abnormalities among American

Indian school children for an entire school population, and compared the results with Caucasian school children. The Lame Deer Study produced the following results:

- The mean percentage of Indian children who manifest vision problems is 51.6%.
- The mean percentage of Caucasian school children who manifest vision problems is less than half the Indian figure, or 20.9%.
- For the vision condition of myopia, or nearsightedness, a mean 27.9% of Indian children were referred for further examination and treatment, compared to 7.8% for Caucasian children.
- For another vision condition, astigmatism - an irregularity in the shape of the cornea - some 32.9% of Indian children presented with this condition as compared with only 1.5% of their Caucasian counterparts.

Over the last few years, statistics developed by the Indian Health Service and AOA have also revealed:

- Mild conjunctivitis (allergic and vernal) is extremely common among Native Americans.
- Reduced vision is a common condition suffered by older American Indians, with a high correlation of positive tuberculosis reaction.
- Trachoma is common in the Indian population of the Southwest.

- Glaucoma is especially prevalent among Alaskan natives.

The Lame Dear Study concludes that one of every three Indian children entered school with a vision problem, compared to one of every sixteen Caucasian children of the same grade. By grade 12, more than two of every three Indian children had v[illegible]ems, compared to one of three Caucasians.

At the time of the Lame Dear Study the Indian Health Service employed fewer than twenty optometrists. Consequently almost 60% of all Indian children and fully 90% of Indian adults received limited or no eye care. However over the past decade, the IHS has doubled its optometry staff (now approximately 44 optometrists) with the result that most of the school aged Indian children are receiving some type of optometric care. Yet little improvement has been accomplished for adult vision care; almost 90% of Indian adults still receive limited or no vision care. When tribal committees, community groups, and various advisory committees are polled regarding vision care, three elements are most frequently requested:

- Adult refraction program
- Free, or inexpensive eyeglasses for adults
- Peripheral ophthalmology clinics

These requests clearly reflect a demand for services to examine, diagnose and treat vision conditions. It is the understanding of the AOA that the IHS is making significant progress in reducing the Indian versus Caucasian incidence of life-threatening and crippling diseases. Now that the infectious disease, morbidity figures and so forth are edging toward national norms, and in recognition of a national goal of providing the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level, the AOA maintains it is now time to attack the great disparity in the vision health of the Indian population.

SPECIFIC COMMENTS AND RECOMMENDATIONS ON S.277

Title I - Indian Health Manpower

The AOA supports the continuation of the programs designed to increase the number of Indian people entering the health professions; optometry has been a part of the health professions preparatory scholarship program as well as the Indian health professions scholarship program. However, the AOA is concerned about the degree of involvement. To date, there is only one American Indian optometrist serving in the IHS who is a product of this scholarship program. In view of the overwhelming unmet need for adult Indian eye care, AOA maintains the Secretary should give careful consideration to optometry students when the distribution of the IHS scholarships is determined.

Regarding the existing Community Health Representative Program which S. 277 would have authorized under the Snyder Act, the AOA strongly supports this initiative as well as the continuing provision itself, but with one revision. Absent in the list of health promotion and disease prevention activities is any mention of vision care. As evidenced by the above mentioned demonstratable need for vision care services, AOA believes the Community Health Representative Program should include instruction in the area of prevention and management of vision problems for the community health representatives.

representatives. On a small scale, a few community health representatives are currently employed as optometric technicians, who are serving a vital role in the delivery of optometric care ot the Indian population. With the specific addition of prevention and management of vision problems vision screening to the curriculum of the community health representatives, IHS can begin to identify those in the adult population who require further vision services.

RECOMMENDATION:

> AOA recommends the addition of prevention and management of vision problems as a health promotion and disease prevention activity, when the IHS develops the curriculum for the Community Health Representative Program.

Title II - Health Services

This title extends and amends existing law (25 U.S.C. 1621) for the IHS direct patient care program. P.L. 94-437 specified the direct patient care program was to address "... backlogs in Indian health care services and to supply known, unmet medical, surgical, dental, optometrical, and other Indian health needs..." (emphasis added). S.277 amends 25 USC 1621 (a)(b)(c) (P.L. 94-437) by naming the following health service responsibilities instead of the above one of P.L. 94-437:

"(A) clinical care (direct or indirect);

(B) preventive health;

(C) dental care (direct or indirect)

(D) mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional Indian practitioners;

(E) emergency medical services;

(F) treatment and control of, and rehabilitative care related to, alcoholism among Indians; and

(G) maintenance and repair."

Specific mention of optometric care is missing from this listing of health service responsibilities, and the AOA is concerned that much needed vision care may again be ignored. As mentioned in the introductory remarks to this statement, IHS has begun to respond to the vision care needs of Indian children. But the adult population still has yet to be addressed. Even with the benefit of a specific mention of optometric care in P.L. 94-437, the corps of dedicated IHS optometrists have struggled to meet the demands of just one segment of the Indian population - the school aged Indians. Recently, vision care, both optometric and ophthalmologic, has been incorporated into funding for patient care with the result that the IHS Optometry Consultant (or Ophthalmology Consultant) may not ensure funding of optometry services at any Area or Service Unit level, as the Area Directors have the perogative to use non-line item funds for any purpose within the general areas of patient care. A major complaint of IHS optometrists is that the lack of line item funding has seriously hampered the development of the IHS optometry program. Additionally, the lack of line item funding has led to the inequity of funds and resources among the Areas; some Areas are better staffed, equipped and funded than other Areas.

Section 201 (h) of S.277 authorizes funds for the express purposes of clinical care, preventative health, dental care, mental health, alcoholism treatment and so forth. AOA supports these important programs. However, because of the above mentioned chronic problems experienced in vying for funds, even with specific mention in statute for optometric services, the AOA suggests an amendment of Sec. 201 (b)(1) of S.277.

RECOMMENDATION:

AOA recommends the specific addition of preventive and clinical eye/vision care to the list of health service responsibilities contained in
Sec. 201 (b)(1)(A)

The suggested amendment would read, and following "(B) preventive health;":

"(C) preventive and clinical eye/vision care;".

Such an amendment would maintain the institutional memory that vision care services are a stated priority, a priority that, for the adult Indians, has not been addressed.

Title III - Health Facilities

Under this title S.277 provides authority for the construction and renovation of Indian Health Service facilities and for the construction of safe water and sanitary waste disposal facilities. The AOA supports funding for construction and renovation of hospitals and health centers. Of course, as a basic health issue, the AOA supports funding of sanitary waste disposal facilities as well.

Title IV - Access to Health Services

Title IV extends authority of existing law regarding participation in the Medicare and Medicaid programs. AOA supports the provisions in Title IV which enable reimbursement to be made from the Medicare and Medicaid programs.

Title V - Urban Indian Health Services

AOA supports this provision of S.277.

Title VI - Organizational Improvements

Among other features, title VI elevates the IHS from a bureau level to that of an agency level within the Public Health Service. Supporting functions and authorities would be within the IHS and it would be removed from of the jurisdiction of the Health Resources and Services Administration

It is the position of the AOA that the IHS deserves an important level of priority within DHHS. Any personnel mechanism which would improve the existing management and effectiveness of IHS is desirable. Any change as offered by Sec. 602 of S.277 which would eliminate layers of bureaucracy, enhance accountability and place all functions under a single individual, is supported by the AOA.

CONCLUSION

The American Optometric Association enthusiastically supports continuation of Indian health programs as well as the concept embodied in S.277 which allocates appropriated funds to those tribes with a greater health deficiency as identified by the IHS Priority System.

The AOA concludes, that the stress on Indian self-determination is largely dependent upon the Indian's ability to learn and to perform tasks requiring an adequately functioning visual system. Yet we handicap these potential self-determiners by almost totally ignoring the adult population as well as a good percentage of the child population, and this is in a population that demonstrates a much higher percentage of visual problems than the population in general. How can we expect Indians to be the masters of their fate when we deprive them of their main tool to work with - good vision?

The AOA encourages favorable action on S.277, with the alterations for improvement detailed in the above text. These amendments are entirely in keeping with the thrust of this legislation.

PREPARED STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

The American Psychological Association (APA) is pleased to provide testimony for the hearing record of the Select Committee on Indian Affairs on S. 277, a Bill to Reauthorize the Indian Health Care Improvement Act of 1976.

APA is concerned with the total health care of all individuals and in particular, the relationship and integration of health and mental health. Thus, we recognize the need for and strongly support continued Indian Health Care Service as part of the Department of Health and Human Services. In particular we are pleased to note that the Bill contains the following provisions.

Title I: INDIAN HEALTH MANPOWER

1. The Health Professions Recruitment Program that identifies Indian students in junior and senior high school who demonstrate proficiency in academic coursework related to the health professions, and orients such students to pursue higher education in the health professions.

2. The Indian Health Professions Preparatory Scholarship Program that assists Indian students in undergraduate study to prepare those students for graduate health professions education.

3. The Indian Health Professions Scholarship program that provides scholarship assistance to Indian students pursuing graduate study in health professions in exchange for their commitment to serve in the

Indian Health Service, in an urban Indian health care program, or in an Indian community, upon graduation. We especially appreciate the specific inclusion of Indians enrolled in schools of clinical psychology. Study in psychology as a health service profession focuses on understanding the relationship between mental and physical condistions and has made significant contributions in integrating these aspects of health care. The inclusion of psychology, allied health, and public health, especially, assure that a broad range of necessary health promotion and prevention specialists can receive support under the manpower part of this program.

4. The Indian Health Service Extern program that authorizes employment experience in the Indian Health Service during non-academic periods for Indian Health Professions scholarship recipients.

Title II: HEALTH SERVICES

1. Extending authority for programs to eliminate existing backlogs in clinical care, preventive health, dental care, mental health, emergency medical services, alcoholism treatment and rehabilitation, and maintenance and repair.

2. The new provision in Title II which allows the Secretary of the Department of Health and Human Services to annually submit to the Congress a report on the deficiency level of health resources for each Indian tribe or service unit of the Indian Health Service, and to allocate appropriated funds to tribes or service units with a greater level of deficiency before any funds are allocated to tribes or service units with a lesser level of deficiency. We would like to urge special attention to the mental health component in the assessment of health resources, and the careful attention to resource funding so that these needs are not ignored in allocations.

3. The final new addition to Title II authorizing the Secretary of the Department of Health and Human Services to provide health promotion and disease prevention services to eligible Indian patients through the Indian Health Service. Health promotion activities include smoking cessation, reduction in the misuse of alcohol and drugs, improvement of nutrition, improvement in physical fitness, and control of stress. These all reflect behavioral aspects of health care whose modification and control are essential to assure healthier, longer, and more productive lives. We encourage the Committee to include an emphasis on these behavioral health aspects under the direction of psychologists in the health promotion portion.

Title VII: MISCELLANEOUS

1. A new provision of Title VII directs the Secretary of Health and Human Services to enter into an agreement with the Secretary of the Department of the Interior and the Secretary of the Department of Education to coordinate the efforts of the departments related to alcohol and drug abuse among Indian juveniles. The Secretary is further directed to establish an Office of Alcohol and Drug Abuse within the Indian Health Service. We encourage the Committee to place an emphasis on other illnesses among Indians in addition to alcohol and drug abuse. For example, anxiety, depression, and underlying cultural related issues are commonly associated with these illnesses. Therefore, we urge the Committee to include provisions directed at training programs that go beyond the symptoms of substance abuse itself and aim at the underlying causes of such abuse. Training could be directed at communities to heighten awareness of the causes of substance abuse and increase efforts to control or curtail it at an early stage.

2. Title VII directs the Secretary of the Department of Health and Human Services to conduct a study of the physical and mental health care needs of Native Hawaiians and other Native American Pacific Islanders. The Secretary is required to submit a report to the

Congress on this issue. We commend the interagency and collabortive nature of this effort and the Committees efforts to get quality information and data in such a comprehensive way. Since there is a very limited amount of data collected to address the mental health needs of Indians, APA encourages the Committee to include Indians as well as Native Hawaiians and Native American Pacific Islanders in this study.

We strongly commend the Committes efforts in redrafting this legislation to include special attention to prevention and promotion needs. This foresight assures that the health care delivery systems that the federal government supports will operate in the best long-range interests of its citizens. It helps construct a system which does not just respond to current needs but builds for the future.

The American Psychological Association offers its support and assistance in whatever way possible to assist the Committee in developing attention and support for these critical issues. APA strongly supports S. 277 and urges Congress to act as expeditiously as possible in passing this legislation.

1319B

PREPARED STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION SUBMITTED BY KATHERINE S. McCARTER, MHS, ASSOCIATE EXECUTIVE DIRECTOR

The American Public Health Association, representing a combined national and affiliate membership of nearly 50,000 public health professionals and community health leaders, supports the passage of S.277, the reauthorization of the Indian Health Care Improvement Act of 1976. We urge prompt passage of this important public health legislation.

Last year the Association adopted a resolution expressing concern that the 1984 reauthorization legislation had been vetoed. The resolution pointed out that non-passage of the reauthorization bill would adversely affect health services provided at federal, tribal, rural and urban hospitals and clinics, and students preparing for Indian health careers funded through scholarships. The resolution urged reintroduction and passage of similar legislation in 1985.

We are gratified that Chairman Mark Andrews has moved quickly to introduce S.277 which we note is substantially similar to the legislation of last year. We are particularly pleased that a new health promotion and disease prevention policy initiative has been added to S.277 in order to encourage greater program and funding emphasis on preventive health. We have a special interest, as well, in the existing Indian Community Health Representative program which we believe is the foundation for health promotion and disease prevention activities. This program has been especially successful because its activities are administered through local tribal governments and provide services not generally available through the Indian Health Service.

We are pleased to support S.277 and anxious to work with Congress to ensure its passage.

PREPARED TESTIMONY ON
THE INDIAN HEALTH CARE AMENDMENTS OF 1985
THE BRISTOL BAY AREA HEALTH CORPORATION

Mr. Chairman, my name is Robert Clark. I am the executive director of the Bristol Bay Area Health Corporation. BBAHC is a nonprofit health organization representing the thirty-two Alaska Native villages of the Bristol Bay region. It is recognized by the Indian Health Service as a tribal organization and operates the Bristol Bay Area Hospital under a contract with the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act, Public Law 93-638. We provide health services throughout a 40,000 square mile area (the size of Ohio) and operate the only hospital in that area.

We fully support the reauthorization of the Indian Health Care Improvement Act. While important studies have been made in Indian health since the establishment of the Indian health service in 1955, major deficiencies remain and the goal of providing a health status for Indians and Alaska Natives on a par with other Americans is far from achieved.

We wish particularly to support the enactment of section 404 of the Senate bill. This section provides for a demonstration program under which selected hospitals and clinics being operated by tribal organizations under P.L. 93-638 would be allowed to use the proceeds to improve their own health delivery system.

At present the Social Security Act requires that all such reimbursements for service in IHS-owned facilities be deposited in a special fund by the Department of Health and Human Services and expended IHS-wide for the improvement of facilities. Consequently, while IHS has made some attempt to give IHS facilities the benefit of such collections, no binding guarantee can be made that a hospital will be able to utilize such income to improve the services to its own people.

Generally, we feel that the present system may have contributed to the low level of Mediciaid/Medicare collections. With respect to hospitals like ours, which are operated by a tribal organization although owned by IHS, this is a particularly significant issue. The collection of third-party reimbursements, including Medicaid/Medicare, requires a significant effort in the development and implementation of a management information system with appropriately documented bills and adequate collection procedures. We agree with the testimony of the Tanana Chiefs Conference as to the importance of "incentives for the collection of third party revenues at the local level where they will be effective."

The demonstration program authorized by section 404 of the Senate bill will make clear -- in our opinion -- that local collection and use of Medicare/Medicaid revenues will best serve the Congressional purpose of making significant improvements in health services to Indian and Alaska Native people through the use of funding from outside the IHS appropriation.

We also agree with the testimony submitted by the Tanana Chiefs Conference that the demonstration period should run for five (rather than two) years and that statutory language should be inserted to ensure that reimbursements are used solely for decreasing the health deficiency level as Congress intended when it first amended the Social Security Act to make Medicare/Medicaid reimbursements for services in IHS facilities possible.

We urge that the Senate bill's approach to this important matter be approved by the Congress, with the modifications noted above. Not only would such a step lay the groundwork for increased third-party income for the IHS program but it would demonstrate continued Congressional support for Indian and Alaska Native involvement in the administration of health programs under P.L. 93-638.

With regard to the elevation of the Indian Health Service in order to enhance its ability to deliver health care to Indians, we prefer the House version which would establish an Office of Indian Health and create an Assistant Secretary for Health. On the other hand, we would concur in the Senate version, making the Indian Health Service an agency within the Public Health Service. This change is necessary to ensure that our health and budget concerns are given ample consideration by the Administration and the Congress.

We respectfully request that a copy of this statement be filed with the record of your March 6 hearing on S.277.

Fred B. Hoffman
Chairman

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P.O. Box 38
Concho, Oklahoma 73022

March 1, 1985

Senator Mark Andrews, Chairman
Senate Select Committee on Indian
Affairs
U. S. Senate
Washington, D. C. 20510

Dear Mr. Chairman:

The Cheyenne-Arapaho Tribes of Oklahoma submit the following testimony on their own behalf to the Senate Select Committee on Indian Affairs and to the House Interior and Insular Affairs Committee.

We are requesting that the United States Congress provide to the Cheyenne-Arapaho Tribes of Oklahoma the re-authorization of the Indian Health Care Amendment of 1986 and beyond. Within the context of this amendment, the Tribes make the following requests: Increase in space at the Clinton Indian Hospital, Watonga and Concho Health Centers of the Clinton Service Unit, Indian Health Service; Increase in funds for our present alcoholism Program at Bessie, Oklahoma and funding for a female alcoholism program at Concho, Oklahoma; Continued funding for our Community Health Representative Program which has a budget that is insufficient. Any further cuts in funds would greatly jeopardize the program. The Cheyenne-Arapaho Tribes have an Emergency Medical Service Program. The funding for this program should be re-authorized and established as a line item for Tribal EMS Programs. This EMS Program is needed by the American Indian in the Clinton Service Unit. The program has been very responsive to emergencies when called, and it has provided competent emergency medical services to the injured or seriously ill patients.

We thank you for the opportunity to present you with our needs in the Clinton Service Unit.

Sincerely yours,

FRED B. HOFFMAN, Chairman
Twenty-Fourth Business Committee
Cheyenne-Arapaho Tribes of Oklahoma

ATTACHMENT

Fred B. Hoffman
Chairman

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Congress will soon act on the Indian Health Care Amendment of 1985. The Cheyenne-Arapaho Tribes of Oklahoma encourage you to support the vital legislation which will provide continued health services (Inpatient, Ambulatory Patient, and Field Health) to the American Indian and Alaska Natives in the Clinton Service Unit, Indian Health Service, Oklahoma City, Oklahoma.

The Indian Health Care Improvement Act of 1976 established a national goal of improving the quality of health services to the American Indian and Alaska Native. In 1955, the Indian Health Service was transferred from the Bureau of Indian Affairs, Department of the Interior, to the United States Public Health Service. Significant advances have been made since the transfer and the Enactment of the Indian Health Care Bill of 1976. We have joined our concern with other Indian tribes for the re-authorization of the health care services. The re-authorization of the act would continue to improve the health status of the Cheyenne-Arapaho Tribes of Oklahoma and members of other Indian tribes and Alaska Natives as well.

Specifically, we are concerned of the level of health care services presently available within the Clinton Service Unit, Indian Health Service, Clinton, Oklahoma.

We are requesting for increased services:

1) Increase the square footage of the Health Center, Watonga, Oklahoma, by three rooms. This would include two more offices for the IHS staff and one room for storage space for supplies and equipment.

2) Increase the square footage of the Health Center at Concho, Oklahoma. The present level of personnel at Concho is not adequate. Two (2) more personnel are

needed for the direct patient care program, and there is a need for an X-Ray Department within the facility. Presently, the patients are referred to a contract physician for X-Ray in El Reno, Oklahoma which is nine miles distance from Concho. The Health Care Facility is presently a double-wide trailer and placed alongside is a two-chair dental trailer. The Concho Service area presently lacks a dentist. A dentist from the Clinton Hospital Dental trailer commutes twice a week to Concho to provide services for the Concho area.

3) Increase the square footage of the Clinton Indian Hospital. The health facility in Clinton is the only inpatient care facility in the Oklahoma City Area Indian Health Service that does not provide in-house general surgery, obstetrics and gynecology, pediatrics nor cardiac monitoring. Presently, the hospital compound is a conglomerate of trailers that have been pulled up along-side and "scooted-up" next to the inpatient facility. The contracting of a patient's health problem to health facilities many miles away to Lawton, Oklahoma City or Enid for health care is detrimental to the patient's welfare due to lack of immediate follow-up of treatment and rehabilitation and transportation. The Cheyenne-Arapaho Tribes feel that it is essential that the health care services and facilities at the Clinton Indian Hospital be upgraded to the minimum level of other hospitals in the Oklahoma City Area Indian Health Service (See Exhibit 1).

In March 8, 1979, the Cheyenne-Arapaho Tribes of Oklahoma, submitted testimony to the United States Congress and requested funds for an architectural and engineering feasibility study for the replacement of the Clinton Indian Hospital. This request was denied. The hospital was built in 1934 and is now inadequate and past the stages of renovation. The high morbidity and mortality rate for the Indian people in the Clinton Service Unit, Indian Health Service, is a health problem recognized by the Cheyenne-Arapaho Business Committee, the Veterans Administration, the Indian Health Service, and the Oklahoma State Department of Mental Health (See Exhibit 2). The patient utilization of the Clinton Service Unit is the only service unit in Oklahoma that has experienced a 30% increase in combined inpatient and outpatient services (See Exhibit 3) Preventive health programs have reduced the alcoholism rate from 50% of the population over 16 years in 1970 to 20% in 1984. If we were able to offer to our people the basic services currently being provided at all the other service units in the Oklahoma Area we would, without a doubt have even a greater increase in services than we had last year and a general decrease in morbidity and mortality. The average age of death last year for the people of my tribe was 48 years. It seems logical to me that in an age of star war systems we should at least have a health system that can provide the minimum care needed to live an average life span.

The Cheyenne-Arapaho Tribes of Oklahoma (Tribes) at present have a 20% alcoholism rate in persons of sixteen (16) years old and older. From March, 1984, to present there have been fifty-four deaths among members of the Tribes. At least ten of these deaths were due to cirrhosis of the liver attributed to alcoholism*. In April 17, 1979, Dr. Lewis E. Patrie, M. D., M.P.H., and Mr. Charles F. Bailey (See Exhibit 4) presented a report to the Fourteenth Annual Meeting of the USPHS Professional Association, Phoenix, Arizona, on Alcohol Related Morbidity and Mortality Among Oklahoma Native Americans. The findings were that "The comparable TOTAL alcoholism death rate in the Clinton Service Unit is 182/100,000 which considerably exceeds that of any of the 11 areas". Stratten reported a "death rate of 194/100,000 among Indians of the tribal area".

The resources available to the Cheyenne-Arapaho Tribes to do something about their Alcoholism epidemic has been totally inadequate since the NIAAA transfer of funds to the Indian Health Service in 1975. The present amount of recurring funds to the Tribe's Alcoholism program at Bessie, Oklahoma is $86,000 (Grant Funds). The program is able to function only as a custodial rehabilitation program. The funds provide for a staff of five (Facility Manager, 2-Counselors, 1-Secretary, and 1-Cook). In order to continue, this program needs an additional $100,000.00).The Tribes currently has a 12,000 square foot building that is suitable for an alcohol treatment program at Concho, Oklahoma (formerly BIA Boarding School). At present time there are only 26 treatment beds available for Indian women in the entire state of Oklahoma. We would like to start a women's program at Concho, Oklahoma. The cost for this program would be $300,000 per year. Compared to the hospital care that is now required for alcoholic women a three hundred thousand dollar ($300,000)program would be very cost effective. The alcohol prevention program we now have is not really a program, it is an added duty for tribal and IHS staff. An effective prevention program would cost two hundred thousand dollars ($200,000) and would save millions of dollars in future costs.

The Tribal CHR Program works hand in hand with the IHS staff to not only open access to treatment, but to develop prevention strategies in areas of high risk. The continued funding of this program is essential to the effective prevention of health care to our people.

The Tribe is in its second year of developing an Emergency Medical Service Program. This EMS Program should have recurring base for continued development. At present, the base fund is $106,000 recurring. The emergency room services at Clinton Indian Hospital are sub-standard and do not offer the life support systems normally seen in an emergency room. The EMS system is our life-line to adequate services. The FY-85 base for this program was $185,000.

The total enrollment of the Cheyenne-Arapaho Tribes is 8,8186 as of August 21, 1984, (See Exhibit 5). The Clinton Service Unit is located in the Northwestern part of the State of Oklahoma, (See Exhibit 6). The general population of the area is sparse. The unemployment rate, income level and educational level make the Cheyenne-Arapaho Indians totally dependent to the Clinton Service Unit, Indian Health Service for health care even though the Indian Health Service is not a primary resource but a residual resource.

The arbitrary cuts in the budgets cannot be met by the Tribes to provide continuing health services. If the tribal programs are cut again, the Cheyenne-Arapaho Business Committee fear that the health problems of the Tribe will increase in morbidity and mortality rates again.

Exhibit 1

TABLE 1
INPATIENT-OUTPATIENT WORKLOAD FOR MONTH OF DECEMBER
FOR CLAREMORE SERVICE UNIT

*** INPATIENT WORKLOAD ***	FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
ADULT & PEDIATRIC ADMISSIONS	176	242	612	732	-16.4
ADULT & PEDS INPATIENT DAYS	913	1,086	2,859	3,164	-9.6
ADULT & PEDIATRIC ADPL	29.5	35.0	31.1	34.4	-9.6
ADULT & PEDIATRIC OCCUPANCY	49.1	58.4	51.8	57.3	-9.6
NEWBORN ADMISSIONS	53	93	193	259	-25.5
NEWBORN INPATIENT DAYS	116	195	446	585	-23.8
NEWBORN ADPL	3.7	6.3	4.8	6.4	-25.0
NEWBORN OCCUPANCY	28.8	48.4	37.3	48.9	-23.7
*** OUTPATIENT WORKLOAD ***					
CLAREMORE INDIAN HOSPITAL					
PHYSICIAN VISITS	4,864	5,315	12,194	15,079	-19.1
TOTAL VISITS	7,049	7,290	17,643	21,676	-18.6
DELAWARE DISTRICT-JAY HLTH CTR					
PHYSICIAN VISITS	387	357	1,020	1,115	-8.5
TOTAL VISITS	1,401	1,326	3,726	4,026	-7.5
MIAMI HEALTH CENTER					
PHYSICIAN VISITS	517	900	1,322	2,643	-50.0
TOTAL VISITS	2,547	2,785	6,492	8,287	-21.7
LOCUST GROVE HEALTH STATION					
PHYSICIAN VISITS	6	21	39	52	-25.0
TOTAL VISITS	430	357	1,660	808	105.4
SERVICE UNIT TOTAL					
PHYSICIAN VISITS	5,774	6,593	14,575	18,889	-22.8
TOTAL VISITS	11,427	11,758	29,521	34,797	-15.2

TABLE 1

INPATIENT-OUTPATIENT WORKLOAD FOR MONTH OF DECEMBER
FOR CLINTON SERVICE UNIT

*** INPATIENT WORKLOAD ***	FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
ADULT & PEDIATRIC ADMISSIONS	39	39	130	95	36.8
ADULT & PEDS INPATIENT DAYS	186	263	629	679	-7.4
ADULT & PEDIATRIC ADPL	6.0	8.5	6.8	7.4	-8.1
ADULT & PEDIATRIC OCCUPANCY	42.9	60.6	48.8	52.7	-7.4
NEWBORN ADMISSIONS	0	0	0	0	---
NEWBORN INPATIENT DAYS	0	0	0	0	---
NEWBORN ADPL	0.0	0.0	0.0	0.0	---
NEWBORN OCCUPANCY	0.0	0.0	0.0	0.0	---
*** OUTPATIENT WORKLOAD ***					
CLINTON INDIAN HOSPITAL					
PHYSICIAN VISITS	578	492	1,795	1,798	-0.2
TOTAL VISITS	1,060	916	3,355	3,227	4.0
WATONGA HEALTH CENTER					
PHYSICIAN VISITS	223	261	827	870	-4.9
TOTAL VISITS	440	488	1,713	1,954	-12.3
CONCHO HEALTH CENTER					
PHYSICIAN VISITS	239	243	569	669	-14.9
TOTAL VISITS	386	464	1,194	1,238	-3.6
SERVICE UNIT TOTAL					
PHYSICIAN VISITS	1,040	996	3,191	3,337	-4.4
TOTAL VISITS	1,886	1,868	6,262	6,419	-2.4

TABLE 1

INPATIENT-OUTPATIENT WORKLOAD FOR MONTH OF DECEMBER
FOR KANSAS SERVICE UNIT

*** OUTPATIENT WORKLOAD ***	FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
HOLTON HEALTH CENTER					
PHYSICIAN VISITS	280	303	770	1,087	-29.2
TOTAL VISITS	540	495	1,487	1,650	-9.9
HASKELL SCHOOL HEALTH CENTER					
PHYSICIAN VISITS	319	283	718	1,111	-35.4
TOTAL VISITS	1,307	672	2,930	2,520	16.3
WHITE CLOUD HEALTH STATION					
PHYSICIAN VISITS	0	26	24	51	-52.9
TOTAL VISITS	0	56	28	101	-72.3
SERVICE UNIT TOTAL					
PHYSICIAN VISITS	599	612	1,512	2,249	-32.8
TOTAL VISITS	1,847	1,223	4,445	4,271	4.1

TABLE 1

INPATIENT-OUTPATIENT WORKLOAD FOR MONTH OF DECEMBER
FOR LAWTON SERVICE UNIT

*** INPATIENT WORKLOAD ***	FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
ADULT & PEDIATRIC ADMISSIONS	170	203	529	576	-8.2
ADULT & PEDS INPATIENT DAYS	809	1,113	2,614	2,966	-11.9
ADULT & PEDIATRIC ADPL	26.1	35.9	28.4	32.2	-11.8
ADULT & PEDIATRIC OCCUPANCY	50.2	69.0	54.6	62.0	-11.9
NEWBORN ADMISSIONS	34	68	113	164	-31.1
NEWBORN INPATIENT DAYS	119	185	357	423	-15.6
NEWBORN ADPL	3.8	6.0	3.9	4.6	-15.2
NEWBORN OCCUPANCY	32.0	49.7	32.3	38.3	-15.7
*** OUTPATIENT WORKLOAD ***					
LAWTON INDIAN HOSPITAL					
PHYSICIAN VISITS	2,518	3,058	7,031	9,223	-23.8
TOTAL VISITS	3,552	4,657	11,619	13,887	-16.3
ANADARKO HEALTH CENTER					
PHYSICIAN VISITS	243	244	766	686	11.7
TOTAL VISITS	1,185	1,342	3,842	4,058	-5.3
CARNEGIE HEALTH STATION					
PHYSICIAN VISITS	43	14	110	61	80.3
TOTAL VISITS	420	296	1,378	822	67.6
RIVERSIDE SCHOOL HEALTH CENTER					
PHYSICIAN VISITS	0	0	0	0	---
TOTAL VISITS	49	3	49	23	113.0
SERVICE UNIT TOTAL					
PHYSICIAN VISITS	2,804	3,316	7,907	9,970	-20.7
TOTAL VISITS	5,206	6,298	16,888	18,790	-10.1

TABLE 1

INPATIENT-OUTPATIENT WORKLOAD FOR MONTH OF DECEMBER
FOR PAWNEE SERVICE UNIT

*** OUTPATIENT WORKLOAD ***	FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
PAWHUSKA HEALTH CENTER					
PHYSICIAN VISITS	744	680	1,869	2,041	-8.4
TOTAL VISITS	1,280	1,359	3,165	3,960	-20.1
WHITE EAGLE HEALTH CENTER					
PHYSICIAN VISITS	964	748	2,155	2,280	-5.5
TOTAL VISITS	1,845	1,479	4,064	4,420	-8.1
PAWNEE HEALTH CENTER					
PHYSICIAN VISITS	923	667	2,110	2,132	-1.0
TOTAL VISITS	1,586	1,341	3,547	4,055	-12.5
SERVICE UNIT TOTAL					
PHYSICIAN VISITS	2,631	2,095	6,134	6,453	-4.9
TOTAL VISITS	4,711	4,179	10,776	12,435	-13.3

TABLE 1

INPATIENT-OUTPATIENT WORKLOAD FOR MONTH OF DECEMBER
FOR SHAWNEE SERVICE UNIT

*** OUTPATIENT WORKLOAD ***	FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
SHAWNEE HEALTH CENTER					
PHYSICIAN VISITS	1,766	1,670	4,260	4,511	-5.6
TOTAL VISITS	2,956	2,853	7,192	8,127	-11.5
SERVICE UNIT TOTAL					
PHYSICIAN VISITS	1,766	1,670	4,260	4,511	-5.6
TOTAL VISITS	2,956	2,853	7,192	8,127	-11.5

TABLE 1

INPATIENT-OUTPATIENT WORKLOAD FOR MONTH OF DECEMBER
FOR TAHLEQUAH SERVICE UNIT

*** INPATIENT WORKLOAD ***	FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
ADULT & PEDIATRIC ADMISSIONS	230	263	692	734	-5.7
ADULT & PEDS INPATIENT DAYS	672	903	2,220	2,596	-14.5
ADULT & PEDIATRIC ADPL	21.7	29.1	24.1	28.2	-14.5
ADULT & PEDIATRIC OCCUPANCY	54.2	72.8	60.3	70.5	-14.5
NEWBORN ADMISSIONS	54	57	189	153	23.5
NEWBORN INPATIENT DAYS	154	173	527	469	12.4
NEWBORN ADPL	5.0	5.6	5.7	5.1	11.8
NEWBORN OCCUPANCY	38.2	42.9	44.1	39.2	12.5
*** OUTPATIENT WORKLOAD ***					
W. W. HASTINGS INDIAN HOPITAL					
PHYSICIAN VISITS	3,094	4,880	10,491	14,068	-25.4
TOTAL VISITS	5,138	7,571	19,647	22,794	-13.8
SERVICE UNIT TOTAL					
PHYSICIAN VISITS	3,094	4,880	10,491	14,068	-25.4
TOTAL VISITS	5,138	7,571	19,647	22,794	-13.8

TABLE 1

INPATIENT-OUTPATIENT WORKLOAD FOR MONTH OF DECEMBER
FOR TALIHINA SERVICE UNIT

*** INPATIENT WORKLOAD ***	FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
ADULT & PEDIATRIC ADMISSIONS	87	155	321	454	-29.3
ADULT & PEDS INPATIENT DAYS	468	586	1,483	2,154	-31.2
ADULT & PEDIATRIC ADPL	15.1	18.9	16.1	23.4	-31.2
ADULT & PEDIATRIC OCCUPANCY	29.0	36.4	31.0	45.0	-31.1
NEWBORN ADMISSIONS	23	37	73	98	-25.5
NEWBORN INPATIENT DAYS	60	79	213	247	-13.8
NEWBORN ADPL	1.9	2.5	2.3	2.7	-14.8
NEWBORN OCCUPANCY	16.1	21.2	19.3	22.4	-13.8
*** OUTPATIENT WORKLOAD ***					
TALIHINA INDIAN HOSPITAL					
PHYSICIAN VISITS	1,365	2,581	4,761	7,287	-34.7
TOTAL VISITS	1,497	3,061	5,591	9,067	-38.3
J. ANDERSON-BROKEN BOW H CENTR					
PHYSICIAN VISITS	212	423	837	1,142	-26.7
TOTAL VISITS	692	800	2,590	2,206	17.4
HUGO HEALTH CENTER					
PHYSICIAN VISITS	324	588	923	1,714	-46.1
TOTAL VISITS	568	1,086	2,123	3,275	-35.2
MCALESTER HEALTH CENTER					
PHYSICIAN VISITS	353	362	1,181	1,325	-10.9
TOTAL VISITS	765	933	2,656	2,963	-10.4
JONES ACADEMY SCHOOL HLTH STAT					
PHYSICIAN VISITS	0	0	0	37	-100.0
TOTAL VISITS	0	25	4	162	-97.5
SERVICE UNIT TOTAL					
PHYSICIAN VISITS	2,254	3,954	7,702	11,505	-33.1
TOTAL VISITS	3,522	5,905	12,964	17,673	-26.6

TABLE 1

INPATIENT-OUTPATIENT WORKLOAD FOR MONTH OF DECEMBER
FOR ADA SERVICE UNIT

*** INPATIENT WORKLOAD ***	FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
ADULT & PEDIATRIC ADMISSIONS	143	162	507	478	6.1
ADULT & PEDS INPATIENT DAYS	710	834	2,249	2,346	-4.1
ADULT & PEDIATRIC ADPL	22.9	26.9	24.4	25.5	-4.3
ADULT & PEDIATRIC OCCUPANCY	44.9	52.8	47.9	50.0	-4.2
NEWBORN ADMISSIONS	55	66	187	160	16.9
NEWBORN INPATIENT DAYS	165	162	499	377	32.4
NEWBORN ADPL	5.3	5.2	5.4	4.1	31.7
NEWBORN OCCUPANCY	38.0	37.3	38.7	29.3	32.1
*** OUTPATIENT WORKLOAD ***					
ADA INDIAN HOSPITAL					
PHYSICIAN VISITS	3,326	1,767	7,937	8,294	-4.3
TOTAL VISITS	4,930	2,696	11,396	12,372	-7.9
TISHOMINGO HEALTH CENTER					
PHYSICIAN VISITS	731	773	1,893	2,138	-11.5
TOTAL VISITS	980	1,209	2,551	3,499	-27.1
WEWOKA HEALTH CENTER					
PHYSICIAN VISITS	1,018	1,053	2,611	2,807	-7.0
TOTAL VISITS	2,346	2,308	5,744	6,683	-14.1
SERVICE UNIT TOTAL					
PHYSICIAN VISITS	5,075	3,593	12,441	13,239	-6.0
TOTAL VISITS	8,256	6,213	19,691	22,554	-12.7

TABLE 2

INPATIENT WORKLOAD SUMMARY FOR MONTH OF DECEMBER
FOR OKLAHOMA AREA

*** INPATIENT WORKLOAD ***	FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
ADULT & PEDIATRIC ADMISSIONS	845	1,064	2,791	3,069	-9.1
ADULT & PEDS INPATIENT DAYS	3,758	4,765	12,054	13,905	-13.3
ADULT & PEDIATRIC ADPL	121.2	154.4	131.0	151.1	-13.3
ADULT & PEDIATRIC OCCUPANCY	45.1	57.4	48.7	56.2	-13.3
NEWBORN ADMISSIONS	219	321	755	834	-9.5
NEWBORN INPATIENT DAYS	614	794	2,042	2,101	-2.8
NEWBORN ADPL	19.8	25.6	22.2	22.8	-2.6
NEWBORN OCCUPANCY	30.5	39.4	34.1	35.1	-2.8

TABLE 3

O/P WORKLOAD BY SERVICE UNIT FOR MONTH OF DECEMBER
FOR OKLAHOMA AREA

*** SERVICE UNIT ***		FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
CLAREMORE						
	PHYSICIAN VISITS	5,774	6,593	14,575	18,889	-22.8
	TOTAL VISITS	11,427	11,758	29,521	34,797	-15.2
CLINTON						
	PHYSICIAN VISITS	1,040	996	3,191	3,337	-4.4
	TOTAL VISITS	1,886	1,868	6,262	6,419	-2.4
KANSAS						
	PHYSICIAN VISITS	599	612	1,512	2,249	-32.8
	TOTAL VISITS	1,847	1,223	4,445	4,271	4.1
LAWTON						
	PHYSICIAN VISITS	2,804	3,316	7,907	9,970	-20.7
	TOTAL VISITS	5,206	6,298	16,888	18,790	-10.1
PAWNEE						
	PHYSICIAN VISITS	2,631	2,095	6,134	6,453	-4.9
	TOTAL VISITS	4,711	4,179	10,776	12,435	-13.3
SHAWNEE						
	PHYSICIAN VISITS	1,766	1,670	4,260	4,511	-5.6
	TOTAL VISITS	2,956	2,853	7,192	8,127	-11.5
TAHLEQUAH						
	PHYSICIAN VISITS	3,094	4,880	10,491	14,068	-25.4
	TOTAL VISITS	5,138	7,571	19,647	22,794	-13.8
TALIHINA						
	PHYSICIAN VISITS	2,254	3,954	7,702	11,505	-33.1
	TOTAL VISITS	3,522	5,905	12,964	17,673	-26.6
ADA						
	PHYSICIAN VISITS	5,075	3,593	12,441	13,239	-6.0
	TOTAL VISITS	8,256	6,213	19,691	22,554	-12.7
TOTAL OKLAHOMA AREA						
	PHYSICIAN VISITS	25,037	27,709	68,213	84,221	-19.0
	TOTAL VISITS	44,949	47,868	127,386	147,860	-13.8

TABLE 1

O/P WORKLOAD BY SERVICE UNIT FOR MONTH OF DECEMBER
FOR OKLAHOMA - 638 SERVICE UNIT

*** OUTPATIENT WORKLOAD ***	FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
OKEMAH HLTH CENTER - 638					
PHYSICIAN VISITS	417	466	1,323	1,644	-19.5
TOTAL VISITS	743	723	2,551	2,395	6.5
SAPULPA HLTH CENTER - 638					
PHYSICIAN VISITS	653	745	1,789	2,169	-17.5
TOTAL VISITS	867	1,052	2,929	3,236	-9.5
SERVICE UNIT TOTAL					
PHYSICIAN VISITS	1,070	1,211	3,112	3,813	-18.4
TOTAL VISITS	1,610	1,775	5,480	5,631	-2.7

TABLE 1

O/P WORKLOAD BY SERVICE UNIT FOR MONTH OF DECEMBER
FOR SERVICE UNIT

*** OUTPATIENT WORKLOAD ***	FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
EUFAULA HLTH CENTER - 638					
PHYSICIAN VISITS	719	496	2,109	1,274	65.5
TOTAL VISITS	1,122	997	3,435	3,029	13.4
SALLISAW HEALTH CTR - 638					
PHYSICIAN VISITS	92	87	277	210	31.9
TOTAL VISITS	158	214	628	708	-11.3
STILWELL HEALTH CTR - 638					
PHYSICIAN VISITS	712	329	1,984	1,326	49.6
TOTAL VISITS	991	579	3,303	2,284	44.6
SERVICE UNIT TOTAL					
PHYSICIAN VISITS	1,523	912	4,370	2,810	55.5
TOTAL VISITS	2,271	1,790	7,366	6,021	22.3
TOTAL OKLA - 638 AREA					
PHYSICIAN VISITS	2,593	2,123	7,482	6,623	13.0
TOTAL VISITS	3,881	3,565	12,846	11,652	10.2

TABLE 1

O/P WORKLOAD BY SERVICE UNIT FOR MONTH OF DECEMBER
FOR OKLA. AREA URBAN PROJECTS

*** OUTPATIENT WORKLOAD ***	FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
WICHITA URBAN PROJECT					
PHYSICIAN VISITS	0	171	0	562	-100.0
TOTAL VISITS	0	268	0	838	-100.0
TOTAL OKLA URBAN AREA					
PHYSICIAN VISITS	0	171	0	562	-100.0
TOTAL VISITS	0	268	0	838	-100.0

TABLE 1

O/P WORKLOAD BY SERVICE UNIT FOR MONTH OF DECEMBER
FOR CREEK-NATION AREA

*** OUTPATIENT WORKLOAD ***	FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
OKMULGEE CLINIC					
PHYSICIAN VISITS	190	121	502	306	64.1
TOTAL VISITS	191	239	620	708	-12.4
TOTAL CREEK AREA					
PHYSICIAN VISITS	190	121	502	306	64.1
TOTAL VISITS	191	239	620	708	-12.4

EXHIBIT 2

REPORT OF THE APRIL 26, 1977 HEARING ON INDIAN CIVIL RIGHTS ISSUES IN NORTHWESTERN OKLAHOMA

1907

Oklahoma Human Rights Commission
Jim Thorpe Office Building
Oklahoma City, Oklahoma 73105

Tribal Resource Development
Cheyenne - Arapaho Tribes
Concho, Oklahoma

III. STATISTICAL SURVEY OF SOCIOECONOMIC CONDITIONS OF CHEYENNE-ARAPAHO INDIANS

This section is devoted to a survey of social and economic indicators of the Cheyenne-Arapaho Indians of Northwestern Oklahoma. The population of the Cheyenne-Arapaho in the six-county area which we are considering is approximately 4,000, which is about 4% of the total population. While the number of the population is relatively small, the problems facing the Cheyenne-Arapaho, graphically depicted in this section, are far from minor in nature. Table I shows the population for each of the six counties. Table II shows Indian population by county broken down into age groups and as a percentage of the total population. While the 21-64 year age group represents the largest age group within the Indian population, notice that the 0-20 year age group represents the larger proportion of the total population. Thus, in the school age group there exists the higher ratios of 12.4%, 9.7% and 8.7% to the non-Indian school age population in Roger Mills, Blaine, and Dewey counties, respectively.

The relatively small population of the Cheyenne-Arapaho Indians contrasts with the high ratios that exist for poverty level status and persons receiving public assistance. Table III shows family income and poverty status of the Indian population for three of the six counties in our study. In Blaine county Indians represent an astounding 47% of the total number of people earning under $3,000 per year. In Canadian County, even though the median income is $8,167 for Indian families, Indian people make up 19% of the total number earning under $3,000 per year. For all persons living in Blaine, Canadian, and Custer Counties, Indians make up 55.2%, 47.8%, and 41.4% respectively, of the total number earning less than a poverty level income.

It is interesting to compare the information in Table III with that in Table IV, per capita personal income by County. The per capital income for all

TABLE I

ESTIMATED INDIAN POPULATION BY COUNTY
FISCAL YEAR 1977

County	Total	% of 6 Counties	% of Indians in Okla.*
Blaine	711	18.33%	.59%
Canadian	1,474	38.0%	1.23%
Custer	824	21.24%	.69%
Dewey	259	6.68%	.22%
Kingfisher	293	7.55%	.24%
Roger Mills	318	8.20%	.27%
	3,879	100%	3.24%

*Total Indian Population estimated at 119,790

Source: Indian Health Services, June 1976.

TABLE II

ESTIMATED POPULATION BY COUNTY AND AGE GROUPING
As of April 1, 1974

	TOTAL		0-20 Yrs Old		21-64 Yrs Old		65 Yrs or Older	
	Population	% Indian	Population	% Indian	Population	% Indian	Population	% Indian
Blaine County								
Total	11,996		4,110		5,772		2,114	
Total Indian	766		400		321		45	
% Indian		6.38%		9.73%		5.56%		2.13%
Canadian County								
Total	34,593		13,380		17,493		3,720	
Total Indian	1,262		767		446		49	
% Indian		3.65%		5.73%		2.55%		1.32%
Custer County								
Total	24,010		9,103		12,070		2,837	
Total Indian	828		398		382		48	
% Indian		3.45%		4.37%		3.16%		1.69%
Dewey County								
Total	5,698		1,760		2,931		1,007	
Total Indian	259		153		86		20	
% Indian		4.54%		8.69%		2.93%		1.99%
Kingfisher County								
Total	13,746		5,057		6,729		1,960	
Total Indian	257		133		109		15	
% Indian		1.87%		2.63%		1.62%		.76%
Roger Mills County								
Total	4,415		1,408		2,257		750	
Total Indian	317		175		122		20	
% Indian		7.18%		12.43%		5.40%		2.67%
County Totals (6)								
Total	94,458		34,818		47,252		12,388	
Total Indian	3,689		2,026		1,466		197	
% Indian		3.90%		5.82%		3.10%		1.59%
State of Oklahoma Totals								
Total	2,666,200		992,800		1,357,100		316,300	
Total Indian	105,200		48,450		47,150		9,600	
% Indian		3.94%		4.88%		3.47%		3.04%

Source: State of Oklahoma, DISRS Report, 1975

TABLE III

FAMILY INCOME AND POVERTY STATUS OF THE INDIAN POPULATION, 1970*

	Blaine		Canadian		Custer	
Income of Families	Number	%	Number	%	Number	%
All Families	203	100.00	131	100.00	89	100.00
$1,000-$2,999	96	47.29	26	19.85	35	39.32
$3,000-$5,999	35	17.24	29	22.14	19	21.35
$6,000-$8,999	62	30.54	18	13.74	19	21.35
$9,000-$11,999	--	--	15	11.45	10	11.24
$12,000-$14,999	10	4.93	29	22.14	2	2.25
$15,000-$24,999	--	--	14	10.68	4	4.49
$25,000 and Over	--	--	--	--	--	--
Median Income	$3,183		$8,167		--	
Per Capital Income of Unrelated Persons	$ 999		$1,292		$ 921	
Income Less Than Poverty Level						
Percent of All Persons	55.2%		47.8%		41.4%	
Percent of All Families	55.2%		27.5%		--	

*Only those counties with 400 or more Indians in 1970 were included in this table.

Source: Bureau of the Census, U. S. Department of Commerce, 1970.

TABLE IV

PER CAPITA PERSONAL INCOME BY COUNTY AND RANK IN STATE 1975

County	Rank*	Per Capita Personal Income
Blaine	29	$4,789
Canadian	16	$5,500
Custer	18	$5,486
Dewey	22	$5,106
Kingfisher	8	$6,135
Roger Mills	36	$4,668

*77 Counties in Oklahoma

Source: Survey of Current Business, April 1977.

races listed in Table IV shows Blaine County at $4,789 which is $1,600 higher than the family income listed for Indian families in Table III. In Table V Indian persons receiving public assistance is broken down by county and age group, and as a percentage of the total number of people receiving assistance. In all age groups and all counties, Indians reflect a proportion many times that of their population in the county. Even Canadian County, where the ratio of Indians receiving public assistance to the total is lowest, there is still an Indian ratio double that of their population rate.

With poverty comes other problems, particularly ill health. The median age at death for the Cheyenne-Arapaho female is 46 years. The median age at death for a White female is 76 years. The median age at death for an Indian male is 51 years, while for a White male it is 70 years. This disparity between median age at death for Indian and White is astounding.

Table VI shows alcohol related deaths for Indians in the six-county area. Alcoholism is one of the major health and social problems facing Native Americans today. In Blaine County Indians represent 100% of the small number of alcohol related deaths for 1976. In addition to health problems, alcohol abuse can contribute to the problems of unemployment, low income, and even children's drop-out rates from school due to lack of a healthy home situation.

In rural Oklahoma only 28.2% of Indians graduate from high school. The median school years completed for a rural Indian is 8.9. Table VII shows the enrollment and drop-out rates for Indian students for the 1972-73 academic year. In nearly all school systems shown in this table, the Indian drop-out rate exceeds their enrollment rate. The drop-out rates range from a low of 8.7% in Dewey County to 60.0% in Roger Mills County.

Table VIII shows the enrollment report for the 1976 school year of the number and percentage of Indian students by county and grade category. The

TABLE V

PERSONS RECEIVING PUBLIC ASSISTANCE BY COUNTY

1974

	TOTAL		0-20 Yrs Old		21-64 Yrs Old		65 Yrs or Older	
	Total Persons	% Indian	Total Persons	% Indian	Total Persons	% Indian	Total Persons	% Indian
Blaine County								
All Races	913		284		297		332	
Indian	252		158		81		13	
% Indian		27.60%		55.63%		27.27%		3.92%
Canadian County								
All Races	1,400		484		442		474	
Indian	96		54		39		3	
% Indian		6.86%		11.16%		8.82%		.63%
Custer County								
All Races	1,287		505		386		396	
Indian	258		150		84		24	
% Indian		20.05%		29.70%		21.76%		6.06%
Dewey County								
All Races	351		121		91		139	
Indian	96		60		32		4	
% Indian		27.35%		49.59%		35.16%		2.88%
Kingfisher County								
All Races	401		144		112		145	
Indian	72		52		18		2	
% Indian		17.96		36.11%		16.07%		1.38%
Roger Mills County								
All Races	308		92		108		108	
Indian	104		62		32		10	
% Indian		33.77%		67.39%		29.63%		9.26%
County Totals (E)								
All Races	4,660		1,630		1,436		1,594	
Indian	873		536		286		56	
% Indian		18.84%		32.88%		19.92%		3.51%
State of Oklahoma Totals								
All Races	208,434		74,621		67,986		65,827	
Indian	16,270		7,963		5,451		2,827	
% Indian		7.80%		10.67%		8.02%		4.34%

Source: State of Oklahoma DISRS Report, 1975

TABLE VII

ENROLLMENT AND DROPOUT RATES FOR INDIAN STUDENTS
1972-1973 Academic Year

	% of Indian Enrollment	Total Number of Dropouts	% of Indian Dropouts
Blaine County			
Canton	25%	53	58.49%
Geary	16%	41	34.15%
Greenfield	15%	13	15.38%
Longdale	30%	22	86.36%
Watonga	11%	109	24.77%
Canadian County			
Calumet	15%	29	27.59%
El Reno	5%	22	10.13%
Custer County			
Arapaho	24%	26	50.00%
Clinton	6%	136	14.70%
Custer City	15%	15	20.00%
Thomas	6%	45	22.22%
Weatherford	7%	178	7.86%
Dewey			
Seiling	16%	46	8.70%
Kingfisher			
Kingfisher	8%	82	18.29%
Roger Mills			
Hammon	29%	20	60.00%
6 County Total	10%	1,042	20.63%

Source: Cheyenne-Arapaho Office of Education Report, 1974.

TABLE VIII

ENROLLMENT REPORT
OKLAHOMA STATE DEPARTMENT OF EDUCATION
January 11, 1977

	Total Enrollment	Number Indian	% Indian
Blaine County			
Special Education**	28	8	28.57
Grades K-6	1,377	185	13.44
Grades 7-9	689	102	14.80
Grades 10-12	670	55	8.21
Total	2,764	350	12.66%
Canadian County			
Special Education	42	1	2.38
Grades K-6	5,991	294	4.91
Grades 7-9	3,094	223	7.21
Grades 10-12	2,492	55	2.21
Total	11,619	573	4.93%
Custer County			
Special Education	33	4	12.12
Grades K-6	2,346	238	10.14
Grades 7-9	1,155	94	8.14
Grades 10-12	1,008	63	6.25
Total	4,549*	406*	8.92%
Dewey County			
Special Education	5	-	-
Grades K-6	624	39	6.25
Grades 7-9	355	24	6.76
Grades 10-12	335	21	6.27
Total	1,319	84	6.37%
Kingfisher County			
Special Education	-	-	-
Grades K-6	1,592	62	3.89
Grades 7-9	883	19	2.15
Grades 10-12	890	18	2.02
Total	3,365	99	2.94%

TABLE VIII (Cont'd)

Roger Mills County			
Special Education	-	-	-
Grades K-6	250	-	-
Grades 7-9	143	-	-
Grades 10-12	138	-	-
Total	531	-	-
Total Enrollment For 6 Counties			
Special Education	108	13	12.04
Grades K-6	12,180	818	6.72
Grades 7-9	6,319	462	7.31
Grades ~~10-12~~	5,533	212	3.83
TOTAL	24,147*	1,512*	6.26%

*Includes 7 Indian Children enrolled in Nursery School.
**Special Education includes mentally and physically handicapped, learning disabil
emotionally disturbed, gifted and exceptional, etc.

Source: State Department of Education

TABLE XI

UNEMPLOYMENT BY TRIBE, 1975

Tribe	Working Age Population	Not in Labor Force	Labor Force	# Employed	# Unemployed	% Unemployed
Arapaho	1,051	147	904	181	723	80.0
Cheyenne	3,460	932	2,976	595	2,381	80.0
Total	4,511	1,079	3,880	776	3,104	80.0%

Percentage Total State Unemployment	6.6%
Percentage State Indian Unemployment	26.0%

Source: A Summary of Statistics for the Indian in Oklahoma, Oklahoma Indian Affairs Commission, May 1975.

TABLE XII

1975 EMPLOYMENT UTILIZATION

	Total Empl.	White Collar Workers Total	White Collar Workers Managers Officials	White Collar Workers Professionals	White Collar Workers Technicians	White Collar Workers Sales Wrkrs	White Collar Workers Office/ Clerical	Blue Collar Workers Total	Blue Collar Workers Craft	Blue Collar Workers Operatives	Blue Collar Workers Laborer	Service Wrkrs.
% Rate - All 5 Counties												
Total Workers	100%	33.37	8.66	1.28	2.35	5.91	15.17	63.86	27.01	26.59	9.26	2.77
Am. Indian	100%	34.20	7.89	3.95	5.26	2.63	14.47	60.54	15.8	34.21	10.53	5.26
Indians as % of Total	1.68%	1.72	1.53	5.17	3.77	.75	1.60	1.60	.98	2.09	1.91	3.2
% Rate Blaine County												
Total Workers	100%	38.91	18.32	2.71	1.13	2.49	14.25	59.73	16.99	42.76	--	1.36
Am. Indian	100%	19.23	7.69	--	--	--	11.54	80.77	19.23	61.54	--	--
Indians as % of Total	5.88%	2.91	2.47	--	--	--	4.76	7.95	6.67	8.46	--	--
% Rate Dewey County												
% Rate Kingfisher Co.												
Total Workers	100%	73.26	15.14	2.29	8.26	1.38	46.79	24.31	15.14	9.17	--	1.83
Am. Indian	100%	90.91	9.09	9.09	9.09	9.09	54.55	9.09	--	9.09	--	--
Indians as % of Total	5.04%	6.21	3.03	20.0	5.56	33.33	5.88	1.89	--	5.0	--	--
% Rate Roger Mills Co.												
Total Workers	100%	39.13	23.91	--	2.17	4.35	8.7	60.87	13.04	39.13	8.7	--
Am. Indian	--	--	--	--	--	--	--	--	--	--	--	--
Indians as % of Total	--	--	--	--	--	--	--	--	--	--	--	--
% Rate Canadian Co.												
Total Workers	100%	29.90	6.12	.32	1.80	6.01	15.65	68.88	36.33	21.26	11.19	1.22
Am. Indian	100%	20.0	13.33	--	--	6.67	--	73.34	26.67	6.67	40.0	6.67
Indian as % of Total												
% Rate Custer Co.												
Total Workers	100%	31.55	9.32	3.11	3.11	8.16	7.86	60.58	9.32	41.55	9.71	7.86
Am. Indian	100%	33.33	4.17	8.33	12.5	--	8.33	54.16	12.5	33.33	8.33	12.5
Indian as % of Total	2.33%	2.46	1.04	6.25	9.38	--	2.47	2.08	3.12	1.87	2.0	3.70

Exhibit 3

TABLE 3

O/P WORKLOAD BY SERVICE UNIT FOR MONTH OF DECEMBER
FOR OKLAHOMA AREA

*** SERVICE UNIT ***		FY '84 DEC	FY '83 DEC	FY '84 YTD	FY '83 YTD	PCT CHG Y84/Y83
CLAREMORE						
	PHYSICIAN VISITS	5,774	6,593	14,575	18,889	-22.8
	TOTAL VISITS	11,427	11,758	29,521	34,797	-15.2
CLINTON						
	PHYSICIAN VISITS	1,040	996	3,191	3,337	-4.4
	TOTAL VISITS	1,886	1,868	6,262	6,419	-2.4
KANSAS						
	PHYSICIAN VISITS	599	612	1,512	2,249	-32.8
	TOTAL VISITS	1,847	1,223	4,445	4,271	4.1
LAWTON						
	PHYSICIAN VISITS	2,804	3,316	7,907	9,970	-20.7
	TOTAL VISITS	5,206	6,298	16,888	18,790	-10.1
PAWNEE						
	PHYSICIAN VISITS	2,631	2,095	6,134	6,453	-4.9
	TOTAL VISITS	4,711	4,179	10,776	12,435	-13.3
SHAWNEE						
	PHYSICIAN VISITS	1,766	1,670	4,260	4,511	-5.6
	TOTAL VISITS	2,956	2,853	7,192	8,127	-11.5
TAHLEQUAH						
	PHYSICIAN VISITS	3,094	4,880	10,491	14,068	-25.4
	TOTAL VISITS	5,138	7,571	19,647	22,794	-13.8
TALIHINA						
	PHYSICIAN VISITS	2,254	3,954	7,702	11,505	-33.1
	TOTAL VISITS	3,522	5,905	12,964	17,673	-26.6
ADA						
	PHYSICIAN VISITS	5,075	3,593	12,441	13,239	-6.0
	TOTAL VISITS	8,256	6,213	19,691	22,554	-12.7
TOTAL OKLAHOMA AREA						
	PHYSICIAN VISITS	25,037	27,709	68,213	84,221	-19.0
	TOTAL VISITS	44,949	47,868	127,386	147,860	-13.8

EXHIBIT 4

ALCOHOL RELATED MORBIDITY
AND
MORTALITY AMONG OKLAHOMA NATIVE AMERICANS

Lewis E. Patrie, M.D., M.P.H.
and
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Okla[illegible] City Area Indian Health Service
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For Presentation to the Fourteenth Annual Meeting of the USPHS Professional Association, April 17, 1979, Phoenix, Arizona

BACKGROUND

The intent of this paper is to view the scope of alcohol related health problems among Oklahoma Indian people, to examine geographic, age and sex distribution and to suggest some implications.

In attempting to identify mental health problems among Indian people in Oklahoma, a measure of mortality, the median age of death, initially came to our attention. We noted that from 1970-1975 Indian men and women exhibited a nine year reduction in mortality compared with men and women in this state's general population. (Data from Oklahoma State Health Department). A six to seven year reduction is generally reported for U.S. Indians compared with U.S. generally. Adverse infant mortality has been a major factor in this finding; however the Oklahoma Indian infant death rate dropped to less than that of the overall rate for Oklahoma during the last five years. That the median age for Oklahoma Indian men and women was approximately six years younger than that of the overall population (1970 census) offers an explanation for much of the aforementioned difference in mortality.

However, upon examination of the geographic distribution of median age of death a striking finding is noted. Within Clinton, one of Indian Health Service's eight administratively established Oklahoma service units, a marked difference in mortality was observed between Indians and the general population.

Clinton Service Unit consists of the 18 northwestern most counties of Oklahoma. As such it is the largest in area, although it contains the smallest Indian population of the eight service units. Cheyennes and Arapahos constitute the principal Indian population of the Service Unit (6).

MORTALITY

Within Clinton Service Unit Indian men experienced an 18 year and Indian women a 31 year reduction in median age of death (Table I). Infant mortality is not a factor in this low median age of death in as much as the former is less than that for Oklahoma generally although slightly greater than for Oklahoma Indians overall. Furthermore a review of deaths contributing to Clinton Service Unit's low median age of death revealed most were young adults and many apparently alcohol related.

Table II portrays mortality due to alcoholic cirrhosis of the liver in Indians within the eight Oklahoma service units from 1968-1977. The mortality rate of 132 for Clinton Service Unit is more than seven times that for Oklahoma Indians overall. Oklahoma City Area experiences relatively low mortality from alcohol related causes; the "total alcoholism death rate" for this area was 30.4 for the three year period 1974-1976 compared with 59.8 for the overall rate for all 11 areas which includes the entire population served by the Indian Health Service. This total rate included deaths from cirrhosis of the liver with mention of alcohol, alcoholism and alcoholic psychosis as shown in Table III. The comparable "total" alcoholism death rate in Clinton Service Unit is 182/100,000 which considerably exceeds that of any of the 11 areas. Stratton in 1978 reporting on prevalence of alcohol problems on Oklahoma Indians derived similar findings. His reported death rate of 294/100,000 among Indians of the Cheyenne-Arapaho Tribal area reflects a somewhat different population base and time period than that of our report (1).

Kunitz reporting on alcoholic cirrhosis among certain Indian groups cites rates per 100,000 among Navajo, 13-17, Hopi, 104, Apache, 44, age adjusted to a population of 20 years and over (2). Age adjusting the Clinton Service

Unit rate to a base population of 20 years and over increases the rate from 132 to 259.

Reinhard portrays overall mortality from "alcohol liver disease" among the Indian population of eight Arizona Service Units during two seven year periods (3). The lowest reported rate of 9.1 existed among Navajo's during the first seven year period. The highest rate, 144.8, occurred within the Sells Service Unit during the second period. This latter rate was the only one of the 16 which exceeded the aforementioned Clinton Service Unit rate of 132 for alcoholic cirrhosis.

Over a period of years deaths among Oklahoma Indians from alcoholic cirrhosis have appeared to be increasing. During the first five years of our review 91 deaths took place, compared with 124 deaths during the second five year period. X^2 test reveals that such an increase might have occurred by chance less than 0.025 of the time. According to Oklahoma State Health Department records the Cheyenne-Arapaho Indian cirrhosis death rate has increased as follows:

	Rate/100,00
1937-1945	0
1946-1955	9.7
1956-1965	64.5
1966-1975	258.7

The registrar of vital statistics in the county with the largest Indian population within Clinton Service Unit is unable to locate a single record of a death attributable to alcohol among Indian residents prior to 1940. Indian informants maintain that alcohol was not subject to widespread abuse prior to their legal access to alcoholic beverages in the 1950's. Others state that drinking problems followed exposure to alcohol by servicemen during World War II.

Sex and age distribution of alcoholic cirrhosis among Indians within Oklahoma, Table IV, and the Clinton Service

Unit, Table V, are also noteworthy. For all ages, males and females, the Clinton rates greatly exceed those for Oklahoma. For the latter a peak is reached for men and women in the 45-54 age group, while for men within Clinton Service Unit the greatest mortality occurs a decade earlier and for women there are two peaks 25-34 and 45-54. Furthermore mortality among women is approximately 50 percent greater than that for men and their rates for age groups 25-34, 45-54 and 55-64 greatly exceed those for men. Kunitz reported on mortality from alcoholic cirrhosis in terms of case fatality rates (2). Cases of cirrhosis were more numerous among Navajo men, whereas there was a slightly higher (though not significantly so) case fatality rate among women. Among Hopis cases were more common in men, case fatality rates were equal between the sexes. Among Papago Indians, as reported by Reinhard, men experienced a similar magnitude of mortality compared with Cheyenne and Arapaho men in our study, but for the latter mortality was less from age 55 on. Among Cheyennes and Arapahos women displayed consistantly greater mortality in all age groups. In 1979 Reinhard reports Sells Service Unit death rates for female exceed that for male in several age groups among off-reservation people (5). Off reservation rates approach and sometimes exceed the magnitude of the mortality within the Clinton Service Unit. In Reinhard's report of total alcohol liver disease mortality, overall mortality by sex for the eight Arizona service units is nearly equal, with females slightly exceeding male rate in the first seven year period, whereas males exceed females during the second seven years (3). For "White River and San Carlos Service Unit" the female rate is consistantly higher and among five of the other seven service units the female exceeds the male rate during one of the seven year periods.

Table VI shows age specific total alcoholism death rates for U.S. all races, Indians and Alaska Natives, *Oklahoma Indians and Indians within Clinton Service Unit. Peak mortality for Indians occurs at an earlier age than overall U.S. population. One additional earlier peak in age groups 25-34 characterizes Clinton Service Unit. Again Cheyenne and Arapaho mortality greatly exceeds all other populations shown.*

Other forces of mortality within the Clinton Service Unit have an adverse effect on mortality relating to the marked decrease in median age of death. The suicide death rate among Oklahoma Indians 1972-1975 was less than that of the U.S. overall as well as that for Oklahoma overall. During the past ten years the Clinton Service Unit suicide rate has been approximately two to three times that of Oklahoma overall. The victims of 12 of the 13 deaths were between 15 and 45. Homicide rates for Indians in Oklahoma have been approximately double those for the general population during the past ten years, whereas Clinton Service Unit rates have been approximately four times overall Oklahoma rate. The Oklahoma Indian accidental death rate during the last ten years has been approximately one-third higher than that of the general population. For the Clinton Service Unit this rate is approximately four times the overall Oklahoma rate. It is reported anecdotally by many observers that well over half of suicide, homicide and accidental deaths are alcohol related. Along with alcoholic cirrhosis and alcoholism these are the causes of the majority of deaths which produce such profound effects upon the median age of death of the Indian people within the Clinton Service Unit.

MORBIDITY

Morbidity related to alcohol comes to the attention of the Indian Health Service through various means. In Oklahoma most individuals receive direct or contract outpatient or inpatient care. Additional numbers are seen by mental health, social service or community health nursing personnel. Reporting of all encounters is systematized, but not consistant. Our report is limited to data from direct and contract inpatient and outpatient services for the five and one-half year period during which the data system has been operating. Each individual who received one or more services from any IHS facility for what was determined to be primarily an alcohol related problem and was coded as such on the appropriate form, was included in a computerized printout. A summary of the results in Table VII shows some relative differences among the service units. Again, Clinton, with the smallest service population in the area, has the largest number of cases reported. These constitute 18.7 percent of the total population or more than seven times the Oklahoma Indian rate of 2.6 percent.

Because several facilities serve most service units, there exists a certain degree of duplication in the above data. For this reason Table VIII was developed to portray the number of unduplicated individuals served by Clinton IHS Hospital during that five and one-half year period. At least 13 percent of the total service population was seen one or more times for alcohol related illness. The highest rate, 50 percent, was experienced by 25-44 year old males.

Of the total Clinton IHS Hospital cases reported, 22 percent received the diagnosis of alcoholic cirrhosis (Table IX). Of those seen the risk of receiving that diagnosis was about 75 percent greater for women than men.

The risk further appeared to increase with age. This difference is greater than expected by chance with a probability of less than 0.01.

During 1978 tribal alcohol counselor trainees employed via the Comprehensive Education and Training Act conducted a survey by interviewing key people in 13 communities within eight of the Clinton Service Unit's 18 counties to identify as many individuals as possible with "drinking problems". Although the latter term was not clearly defined the results are presented in Table X for comparative purposes. The numbers are remarkably similar to those in Table VIII with the major difference being an increase in numbers of younger persons identified by the trainees.

DISCUSSION

Despite questions of reliability inherent in the data, the reported disproportionate alcohol related morbidity and mortality among Cheyennes and Arapahos within the Clinton Service Unit are so extreme, supported by the low median age of death, reports such as those of Stratton, reports from alcohol counselor trainees and ancedotal reports, that it is difficult to come to any other conclusion than that this rather small group of Indian people are experiencing a profoundly destructive process. Comparing cirrhosis mortality world-wide Schmidt displays age adjusted (25 and older) cirrhosis mortality rates for 18 European counties, Canada and the USA. The highest rate, 57.2 per 100,000 population, is reported for France. The comparably age adjusted alcohol cirrhosis death rate for Oklahoma Indians is 39.4, for Clinton Service Unit 331.8.

Alcohol related problems appear to be increasing with time. Within the past ten years a statistically significant increase in mortality from alcoholic cirrhosis in Clinton Service Unit has occurred. An even more pronounced increase over the past three decades is reported, which is supported by anecdotal information as to morbidity and mortality. This finding is consistant with, but more pronounced than, national and world wide trends (7-11).

As within Clinton Service Unit higher alcoholic cirrhosis death rates for women than men occasionally have been reported. In certain Indian populations (2,3,5) as well as in other groups (7). Furthermore, consistant with our findings, epidemiologic evidence supports increased susceptibility of women to alcoholic liver disease. Besides, women have poorer prognoses once severe disease is established. Rankin cites Péquignot (1958) that persistent daily consumption of 100 ml. of absolute alcohol is accompanied by the risk of developing alcoholic cirrhosis and Wilkinson et al (1969) that alcoholic women drink less per day, but develop cirrhosis at lower levels than their male counterparts (12). Although Rankin's data demonstrate higher rates of cirrhosis among alcoholic women than men in the fourth, fifth, and sixth decades of life, our data reveal a high incidence of cirrhosis in all age groups with women considerably exceeding men (Table IX). Krasner reported on 293 cases of biopsied alcoholic liver disease (13). One category of disease, central sclerosing hyaline necrosis, occurred more commonly among women. In general prognosis improved with abstinence, but was poorer for women than men. Overall men derived significantly greater benefit from abstinence than women. Thaler reports on natural history of alcoholic liver disease: fatty infiltration, alcoholic hepatitis and cirrhosis (14). He documents a quantitative relationship between rate of alcohol consumption, period of exposure and risk of pathology. Citing work of Péquignot (1962) and Lelbach (1967), it is reported that daily absolute alcohol consumption of 60 gm for men, 20 gm for women over a six year period may result in cirrhosis; after 22 years this probability increases to 50 percent. An increase in rate of consumption is accompanied by an increase in risk for both sexes.

The younger age of the Cheyenne and Arapaho individuals with alcohol related morbidity and mortality as compared with Oklahoma Indians and U.S. Indians appears to result from substantially greater and earlier intake of alcohol. The data gathered by alcohol counselor trainees tends to support this. Anecdotal reports from Indian people also stress greatly increased consumption since the 1940's and 1950's especially among younger individuals. Nationwide and world wide greater accessibility to alcohol at declining prices have correlated well with increased consumption and cirrhosis to such an extent that formulas have been worked out which allow for the fairly reliable computation of alcohol consumption given data on cirrhosis and vice-versa (7,12,15).

Besides the direct measures of alcohol related morbidity and mortality which partially explain the marked reduction in median age of death among these Cheyennes and Arapahos, it has been noted that a substantial excess in mortality from accidents, homicide and suicide is contributory. Furthermore, several professional and community informants contacted reported that estimating 50 percent of such deaths as associated with alcohol is a gross understatement.

It is not apparent whether simply increased consumption or other factors are contributing to this very adverse situation. Quantitative studies of drinking patterns have not been conducted among Oklahoma Indians. In accord with our current knowledge of alcohol consumption versus morbidity, this pattern of extremely prevalent alcoholic cirrhosis would necessitate daily intake of the equivalent of more than 177 gm of alcohol for eight years to produce 9.8 percent cirrhosis among persons 15 to 24 as shown in Table IX according to the data reported by Lelbach (15). Similarly it would take the equivalent of about 13 years of consuming 192 gm to result in the 22 percent prevalence for the 25-44 year age group. These two amounts would be the equivalent of approximately two-fifths to one-half gallon of wine or three and one-half to four six packs of beer daily. For women drinkers these figures would presumably be less as indicated above.

Lelbach emphasizes that liver disease of non-alcoholic etiology and/or nutritional imbalance will increase the risk of alcoholic cirrhosis in an unpredictable manner (15). Rankin mentions that hepatitis antigen and history of hepatitis B virus infection apparently predispose to cirrhosis (12). He further states that women experience greater susceptibility to various liver diseases as well as alcoholic cirrhosis, possible due to hormonal factors. Rankin further postulates as yet unknown genetic factors; supporting this is an association discovered between persons with blood groups A and portal cirrhosis in Australia. However he and others find no firm evidence of racial or ethnic determinants of cirrhosis. We have not yet explored a possible association between blood type and cirrhosis among the Cheyennes and Arapahos. However, anecdotal reports suggest that there may be a greater proportion of Cheyennes and Arapahos with blood type A than found in American Indians generally.

IMPLICATIONS

It is difficult to assess the effects of this situation upon the Cheyenne and Arapaho people within the Clinton Service Unit. In reviewing the population distribution by age and sex it is noted that there is under representation within the middle age groups especially among the women. The 1980 census will more precisely reveal the extent of these changes. Health workers in this service unit generally report that their clients are overwhelmed by feelings of depression, hopelessness, low self-esteem, frustration and being victims of unfair circumstances over which they have little or no control. A very high unemployment rate and school dropout rate further add to these feelings. The frequency of deaths often leaves families in a more or less continuous process of grieving. Frequently, anger generated thereby is repressed or misdirected at relatives or other potentially helping people which tends to further interfere with the ability of persons to cope.

It is not clear whether alcohol has been principally used to alleviate this pervasive dysphoria or whether the generally depressant effects of alcohol result in the depressive symptomatology. This question appears academic at this time, because there appears to exist an increasing occurrence of maladaptive coping styles often interacting and reinforcing one another.

More studies could and possibly should be conducted to further understand the overall situation. However, a situation of this magnitude requires planning for action oriented intervention. In part this paper is intended to document this need.

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Acknowledgement: We greatly appreciate the help of Mrs. Elizabeth Ahkeahbo who tirelessly labored under pressure of time through the revisions of this paper to have it ready for presentation today.

TABLE I

Median Age of death Clinton Service Unit and overall Oklahoma 1970-75 by sex.

SOURCE: Oklahoma State Health Department

	Median Age of Death	
	MALE	FEMALE
Overall Oklahoma	69	77
Indians, Clinton Service Unit	51	46
Difference	18 years	31 years

TABLE II

Mortality due to alcoholic cirrhosis among Indians in Oklahoma for the 10 year period 1968 - 1977 by IHS Service Unit and sex.

SOURCES: Mortality - death certificates - Oklahoma State Health Department; Estimated 1975 Oklahoma Indian population by Service Unit - Office of Program Statistics, IHS.

SERVICE UNIT	NUMBER OF DEATHS			MORTALITY RATE Per 100,000 Pop.
	Male	Female	Total	
Claremore	13	6	19	5.3
Clinton	27	40	67	132.5
Lawton	29	17	46	41.4
Pawnee	11	8	19	24.5
Shawnee	14	12	26	11.5
Tahlequah	10	4	14	7.7
Talihina	11	4	15	13.8
Tishomingo	5	4	9	12.1
TOTAL	120	95	215	18.1

TABLE III

Total Alcoholism

Death Rates per 100,000 population for Indians and Alaska Native Residents - 1974-76. Rates include Cirrhosis with mention of Alcohol (ICDA 571.0) Alcoholism (ICDA 303) and Alcoholic Psychosis (ICDA 291).

SOURCE: OPS/IHS - January, 1979

AREAS	DEATH RATE	RANK
Aberdeen	76.4	5
Bemidji	30.7	9
Alaska	61.4	6
Albuquerque	102.7	2
Billings	80.1	4
Navajo	50.6	7
Oklahoma City	30.4	10
Phoenix	83.5	3
Portland	108.1	1
Tucson	49.7	8
United Southeast Tribes	13.7	11
ALL AREAS	59.8	

TABLE IV

Age and Sex distribution of mortality from Alcoholic Cirrhosis among Oklahoma Indians during the 10 year period 1968-77.

SOURCES: Mortality - Oklahoma State Health Department, Total Estimated 1975 Oklahoma Indian Population - OPS/IHS, Age and Sex distribution projected from ratios existant in the 1970 U.S. Census data.

	NUMBER OF DEATHS			MORTALITY RATE PER 100,000 Pop.		
Age Group	Male	Female	Total	Male	Female	Total
15-24	4	2	6	3.7	1.8	3.0
25-34	16	23	39	26.3	36.8	31.6
35-44	36	22	58	67.0	37.2	51.4
45-54	42	32	74	79.8	54.4	66.4
55-64	17	16	33	37.8	30.0	33.6
65 and above	5	0	5	10.7	-	4.6
TOTAL	120	95	215	20.9	15.5	18.1

TABLE V

Age and Sex distribution of Mortality from Alcoholic Cirrhosis among Indian residents of the Clinton Service Unit during the 10 year period 1968-1977.

SOURCES: Mortality - Oklahoma State Health Department, Total Estimated 1975 Oklahoma Indian Population - OPS/IHS, Age and Sex distribution projected from ratios existant in the 1970 U. S. Census data.

	NUMBER OF DEATHS			MORTALITY RATE PER 100,000 Pop.		
Age Group	Male	Female	Total	Male	Female	Total
15-24	2	2	4	41.8	38.2	39.9
25-34	9	14	23	319.1	699.9	468.4
35-44	8	7	15	355.6	272.4	311.2
45-54	7	13	20	295.4	710.4	476.2
55-64	1	4	5	55.6	327.9	165.6
65 and above	-	-	-	-	-	-
TOTAL	27	40	67	107.4	157.4	132.5

TABLE VI

Age Specific Alcoholism Death Rates Per 100,000 Population

(Alcoholic Psychosis, Alcoholism and Cirrhosis of Liver with Mention of Alcohol)

	Indians with Clinton Service Unit *(1968-77)	Oklahoma Indians *(1968-77)	Indians and Alaska Natives **(1974-76)	United States **All Races 1975
Under 15	0.0	0.0	0.0	0.0
15-24	69.9	5.0	1.1	0.4
25-34	631.4	44.6	74.7	3.3
35-44	435.7	71.8	162.5	12.5
45-54	595.2	92.4	172.2	23.7
55-64	264.9	50.9	124.2	27.3
65-74	0.0	9.1	68.2	18.7
75-84			33.8	7.5
85 +			43.2	2.5
TOTAL	181.9	26.3	59.8	8.6

*Estimated 1975 population - same as Table IV.

**Revised data received from OPS/IHS 1978-1979.

TABLE VII

Indian individuals reported to have received health services for alcohol related illness within Oklahoma by Service Unit 1973-1978.

SOURCE: Special printout of direct and contract inpatient and outpatient services - Data Processing Service Center/IHS.

Service Unit	Individuals with alcohol related illness reported 1973-78				
	Male		Female		Total
	No.	%	No.	%	No.
Claremore	168	70%	72	30%	240
Clinton	645	68%	303	32%	948
Lawton	456	70%	199	30%	655
Pawnee	360	69%	163	31%	523
Shawnee	190	80%	27	20%	136
Tahlequah	172	72%	67	28%	239
Talihina	196	78%	56	22%	252
Tishomingo	59	81%	14	19%	73
TOTAL	2,165	71%	901	29%	3,066

TABLE VIII

Sex and Age distribution of Indian Persons with and Prevalence of all Alcohol related illness reported from Clinton Indian Hospital during 5 year period 1973-78.

Source: Special printout of direct and contract inpatient and outpatient services - Data Processing Service Center/IHS.

Persons with all Alcohol Related Illness

	Male		Female		Total	
Age Group	No.	% of Pop.	No.	% of Pop.	No.	% of Pop.
15-24	52	10.8%	30	5.7%	82	8.2%
25-44	252	49.7%	128	27.5%	380	39.1%
45-64	126	30.2%	55	18.0%	181	25.1%
65 and above	20	19.8%	1	0.6%	21	8.0%
TOTAL	451	17.9%	214	8.4%	665	13.2%

TABLE IX

Sex and Age distribution of Indian Persons with Alcoholic Cirrhosis and Percentage of persons with cirrhosis constitute out of all persons with Alcohol related illness.

Source: Special printout of direct and contract inpatient and outpatient services - Data Processing Service Center/IHS.

Persons with Alcoholic Cirrhosis

	Male		Female		Total	
Age Group	No.	%	No.	%	No.	%
15-24	4	7.7%	4	13.3%	8	9.8%
25-44	48	19.0%	35	27.3%	83	21.8%
45-64	25	19.8%	26	47.3%	51	28.2%
65 and above	3	15.0%	1	100%	4	19.0%
TOTAL	80	17.7%	66	30.8%	146	22.0%

TABLE X

Age Distribution of Indian Residents with Alcohol Related Problems in the Clinton Service Unit.

Source: Community survey conducted by Cheyenne-Arapaho CETA Employees under Watonga Network supervision - 1978.

Age Group	Number
15 - 24	192
25 - 44	398
45 - 64	179
65 and over	20
Total	789

EXHIBIT 5.

AUG 21 1984

CHEYENNE-ARAPAHO TRIBE LOCATION:

CONCHO AGENCY POPULATION: TOTAL MEMBERSHIP 8,186 ; on or near former Res. 3,229

ORGANIZATION Constitution and Bylaws adopted:
Charter adopted: Tribal Council
Governing Body: Business Committee Quorum: Not less than 75
Quorum: 5

Annual Tribal Meeting: First Saturday in October of each year
* Elections held: November of Odd-numbered years. (4-yr staggered terms)

* Although Business Committee members are elected for 4 years, the terms of specific offices, such as Chairman, Vice-Chairman, Secretary and Treasurer are subject to two-year terms following each 2 year election.

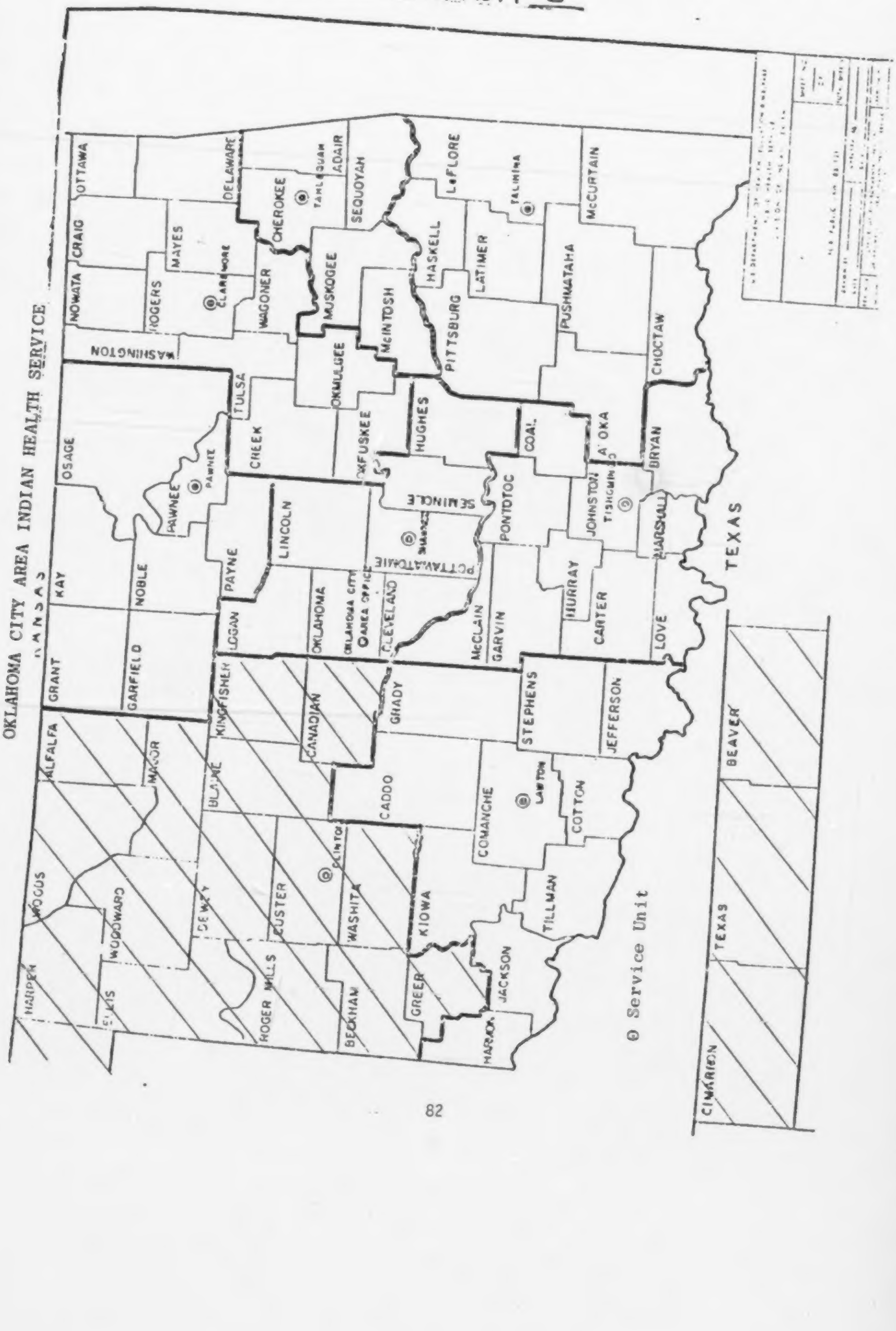
TRIBAL LAND Acres trust: 10,198.57 Acres fee: None
Individual allotments: 247 (75,850a)

COMMUNITY BUILDING

Office address:
Cheyenne-Arapaho Tribal Office P.O. Box 38, Concho, OK 73022 Tele. No. (405) 262-0345

OFFICE	NAME	ADDRESS	TELEPHONE	OCCUPATION	TERM EXPIRES
Chairman	Fred Hoffman (Cheyenne District #4)	Rt. 1, Box 14 Hammon, OK 73650	(H) 473-2338		* 12/85
Vice-Chairman	Wisdom Nibbs, Jr. (Cheyenne District #3)	1505 Orient Clinton, OK 73601	(H) 323-6369		* 12/87
Secretary	Floyd Blackbear (Cheyenne District #1)	304 North Newer Watonga, OK 73772	(H) 623-4520		* 12/87
Treasurer	Clinton Youngbear (Arapaho District #2)	P.O. Box 402 Geary, OK 73040	(B) 262-0345		* 12/87
Sgt. at Arms.	Steve Birdshead (Arapaho District #1)	P.O. Box 383 Canton, OK 73724	(H) 886-2659		* 12/87
Member	Juanita Learned (Arapaho District #2)	2840 NW Grand Blvd. Oklahoma City, OK 73107	(H) 946-6972		* 12/85
Member	Viola Hatch (Arapaho District #1)	Box 448 Canton, OK 73724	(H) 886-3472		* 12/85
Member	Donald Eaglenest (Cheyenne District #2)	306 N. Macomb El Reno, OK 73036	(H) 262-5614		* 12/85

EXHIBIT 6


OKLAHOMA CITY AREA INDIAN HEALTH SERVICE
⊙ Service Unit
KANSAS
TEXAS
CIMARRON
TEXAS
BEAVER
HARPER
WOODS
ALFALFA
GRANT
KAY
OSAGE
WASHINGTON
NOWATA
CRAIG
OTTAWA
DELAWARE
MAYES
ROGERS
CLAREMORE
TULSA
WAGONER
CHEROKEE
TAHLEQUAH
ADAIR
SEQUOYAH
MUSKOGEE
PAWNEE
PAWNEE
NOBLE
GARFIELD
MAJOR
WOODWARD
ELLIS
DEWEY
BLAINE
KINGFISHER
LOGAN
PAYNE
CREEK
OKMULGEE
OKFUSKEE
McINTOSH
HASKELL
LeFLORE
TALIHINA
LATIMER
PITTSBURG
McCURTAIN
PUSHMATAHA
CHOCTAW
HUGHES
COAL
ATOKA
BRYAN
LINCOLN
SEMINOLE
POTTAWATOMIE
SHAWNEE
PONTOTOC
JOHNSTON
TISHOMINGO
MARSHALL
OKLAHOMA
OKLAHOMA CITY AREA OFFICE
CLEVELAND
McCLAIN
GARVIN
MURRAY
CARTER
LOVE
CANADIAN
GRADY
STEPHENS
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LAWTON
COTTON
CUSTER
CLINTON
WASHITA
KIOWA
TILLMAN
ROGER MILLS
BECKHAM
GREER
JACKSON
HARMON

The Chippewa Cree Tribe of the Rocky Boy's Reservation

A RESOLUTION NO: 22-85

TO SUPPORT THE HEALTH CARE BILL PROPOSED BY SENATOR JOHN MELCHER AND TO RESCIND RESOLUTION NO. 14-85.

WHEREAS, THE CHIPPEWA CREE TRIBAL BUSINESS COMMITTEE IS THE GOVERNING BODY OF THE CHIPPEWA CREE TRIBE OF THE ROCKY BOY'S RESERVATION BY THE AUTHORITY OF THE CONSTITUTION AND BY-LAWS OF THE CHIPPEWA CREE TRIBE APPROVED ON THE 23RD DAY OF NOVEMBER, 1935, AND,

WHEREAS, pursuant to the Constitution and By-Laws of the Chippewa Cree Tribe, the Chippewa Cree Tribal Business Committee is charged with the duty of protecting the health, security, and general welfare of the Chippewa Cree Tribe, and,

WHEREAS, the Health Care Bill proposed by Senator John Melcher would serve to actively promote the health, security, and general welfare of the Chippewa Cree Tribe, in keeping with Tribal goals and objectives.

THEREFORE, BE IT RESOLVED that the Chippewa Cree Tribal Business Committee hereby fully supports the Health Care Bill proposed by Senator John Melcher and, further, urges its passage by the Congress of the United States.

BE IT FURTHER RESOLVED that this resolution rescinds Resolution No. 14-85.

CERTIFICATION

I, THE UNDERSIGNED, AS SECRETARY OF THE BUSINESS COMMITTEE OF THE CHIPPEWA CREE TRIBE, HEREBY CERTIFY THAT THE BUSINESS COMMITTEE IS COMPOSED OF NINE MEMBERS OF WHOM 9 MEMBERS, CONSTITUTING A QUORUM, WERE PRESENT AT A MEETING, DULY AND REGULARLY CALLED, NOTICED, CONVENED AND HELD THIS 19th DAY OF MARCH, 1985, AND THAT THE FOREGOING RESOLUTION WAS DULY ADOPTED, AT SUCH A MEETING, BY THE AFFIRMATIVE VOTE OF 8 MEMBERS FOR AND 0 MEMBERS AGAINST AND THAT THIS RESOLUTION HAS NOT BEEN RESCINDED OR AMENDED IN ANY WAY.

Rocky Stump Sr.
CHAIRMAN

Elaine R. [illegible]
SECRETARY, BUSINESS COMMITTEE

COLLEGE OF AMERICAN PATHOLOGISTS

WASHINGTON OFFICE
ALFRED S. ERCOLANO, *Director*
1101 VERMONT AVE., N.W. / SUITE 604
WASHINGTON, D.C. 20005
PHONE 202-371-6617

March 28, 1985

Hon. Mark Andrews
Chairman
Select Committee on Indian Affairs
United States Senate
Washington, DC 20510

Re: S. 277, The Indian Health
Care Amendments of 1985

Dear Mr. Chairman:

The College of American Pathologists is pleased to give its endorsement of S. 277, The Indian Health Care Amendments Act of 1985. We give particular support to that provision (Sec. 203) which provides authority to waive competitive bidding when the procurement of health services, including medical laboratory services, would compromise the accessibility, quality and continuity of health services to American Indians.

The College of American Pathologists is a national group of 10,000 Board-certified physicians who practice in hospital settings, in medical schools, in teaching hospitals, and in independent medical laboratories across the country.

The College submitted a brief statement during hearings held last year on S. 2166, a similar measure which was vetoed by President Reagan. In our statement on S. 2166, the College specifically addressed the use of "competitive bidding" for medical services in general and particularly in connection with the delivery of medical laboratory services. The College stated its strong opposition to the use of "competitive bidding" and indicated that this "opposition is based upon information that clearly demonstrates that the use of bidding has lead to poor laboratory performance. It thus contributes to a deterioration of the very quality of medical laboratory services which is the vital goal in the Indian Health Care Improvement Act, i.e., the provision of excellent health care for Indians covered under the Act."

The College of American Pathologists is pleased that Section 203 has been included in S. 277, and we urge the Committtee to give its approval to this provision before final action is taken on the measure.

We appreciate the opportunity to comment on S. 277, and request that this letter be included in the printed record of its hearings.

Sincerely,

Herbert Derman MD

Herbert Derman, MD
President

PREPARED STATEMENT OF THE COMMISSIONED OFFICERS ASSOCIATION OF THE U.S. PUBLIC HEALTH SERVICE

Mr. Chairman and members of the Committee, the Commissioned Officers Association of the U.S. Public Health Service (COA) appreciates the opportunity to present its views on the Indian Health Care Amendments of 1985, S.277.

The Commissioned Officers Association is a Professional Society representing 85 percent of the active career officers on duty in the Public Health Service (PHS). Our membership includes physicians, dentists, scientists, engineers, nurses, sanitarians, pharmacists, veterinarians, dietitians, therapists, optometrists and general health officers.

The Commissioned Officers Association continues to support and urge enactment of legislation that would reauthorize the Indian Health Care Improvement Act. We continue to believe that such reauthorization is necessary in order that American Indians and Alaskan Natives have a high quality health care program to meet their needs.

The Indian Health Service (IHS), an organizational component of the Public Health Service, has the responsibility to implement a comprehensive medical care and preventive health program for American Indians and Alaska Natives. The IHS functions in and assigns personnel to sparsely populated, often remote and isolated, regions of the country. They function under widely diverse weather extremes and, often, on inhospitable terrain so that health care might be made available to the Native American people. Many Native Americans have been bypassed by the prosperity of our nation and are plagued by major deficiencies in health care, sanitation, housing and other conditions impacting their health.

Therefore, it is imperative that these needs and deficiencies be addressed in a comprehensive, caring and cogent manner that will both maximize benefits to the Native American population and assure the availability of necessary resources to the IHS. The Bill under consideration (S.277) promises to accomplish this to a greater extent than ever before.

With regard to the issue of organizational realignment affecting the IHS, the COA supports IHS organizational elevation within the PHS as outlined in S.277. It remains our view that any organizational change should be undertaken in a manner that will prevent adverse impact on those served by the IHS health care system and on IHS health care providers. The organizational change proposed in S.277 would strengthen the IHS ability to articulate health needs and justify resources necessary to implement appropriate service delivery programs. We believe that satisfactory resolution of this issue depends upon identifying the organizational level that best ensures the provision of optimal health care services to the Native American population while simultaneously ensuring equitable treatment of the IHS personnel providing those services. The COA emphasizes that it s overriding concerns in this regard are for patient welfare and for enhanced capability to accomplish the IHS mission and goals; i.e., meeting the health care needs and improving the health status of the Native American people. Thus, we endorse the establishment of the Indian Health Service as an agency of the Public Health Service.

Mr. Chairman, within this framework, the COA is concerned that the subsequent Directors of the IHS continue to be highly qualified professionals who are knowledgeable concerning the complexities of the IHS program; capable of effectively and efficiently managing that program; and who can best serve the needs of the Native American population. Appointments to the position of Director, IHS, should be stable, and such appointments should be made in a manner that preserves program continuity regardless of changes in the Administration.

Section 601, page 56, contains a 180 day waiver of Indian preference laws for temporary transfers during the implementation of S.277. The COA supports this waiver but would recommend that during and beyond 180 days, upon the recommendation of the Director, IHS, the Assistant Secretary for Health may permanently assign or reassign commissioned officers without regard to Indian preference laws and regulations. The COA strongly believes that such waiver would be in the best interest of both the commissioned officers and the population they serve.

Furthermore, for the foregoing reasons, in the event of a formal Reduction in Strength in PHS, the officers serving in the IHS should be affected and displaced as they would be as members of any other PHS organizational component without regard to Indian preference laws.

Mr. Chairman, as the Commissioned Officers Association has stated in previous testimony, the Public Health Service Commissioned Corps has traditionally played an essential role in the health programs for Native Americans. The IHS simply cannot operate effectively without the Commissioned Corps. More than one-third of all members of the Corps are currently assigned to the IHS. The importance of the Corps to the IHS is underscored by the fact that in excess of 75 percent of most categories of health professionals assigned to IHS are recruited through the Commissioned Corps system. Illustrative examples include: Physicians-78 percent; dentists-98 percent; environmental health sanatarians and engineers-88 percent; and pharmacists-97 percent. Today there are 164 Native American health professionals in the Commissioned Corps and approximately 125 of them are working in the Indian health program. It is, therefore, absolutely essential that the Office of Management and Budget's persistent and continuing campaign to reduce or eliminate the entire Corps as a functioning entity be counteracted vigorously and effectively so that the Corps as a responsive, flexible and essential management tool will be preserved. Should the Commissioned Corps not be properly maintained, vital programs in the IHS and elsewhere in the PHS would suffer irreparable damage and, ultimately, the health of all citizens of our Nation would be adversely affected. Thus, it is in the national interest to maintain a strong, vital, and healthy Commissioned Corps, the efforts and intentions of OMB notwithstanding.

Given this need to assure the continuation of the Commissioned Corps as a vital health care delivery and management resource, we would urge that Sec. 712 regarding the removal of National Health Service Corps members be carefully stated in order to allow the Director, IHS the maximum authority, flexibility and control as necessary to maintain the continuity of care and quality level necessary to meet patients' needs, while, at the same time, preserving full human resource management perogratives.

Mr. Chairman, the Commissioned Officers Association of the United States Public Health Service thanks you for this opportunity to present its views concerning S.277.

CONFEDERATED TRIBES OF THE
Grand Ronde Community Of Oregon
P.O. Box 38
Grand Ronde, OR 97347
PHONE: 879-5211

March 13, 1985

RECEIVED MAR 20 1985

Senator Mark Andrews
Chairman
Senate Select Committee in Indian Affairs
U.S. Senate
Washington, D.C. 20510

The Confederated Tribes of Grand Ronde is in support of the Reauthorization of the Indian Health Care Improvement Act.

The reaffirmation of the national policy proclaimed in the original Public Law 94-437: "In fulfullment of its special responsibilities and legal obligation to the American Indian people, to meet then national goal of providing the highest possible health status to Indians and to provide existing Indian Health Services with all resources necessary to effect that policy," is a statement of paramount importance to the Confederated Tribes of Grand Ronde. In view of the fact the Confederated Tribes of Grand Ronde gained federal recognition status November 22, 1983 and is in dire need of health care services since we have been without these services. The Confederated Tribes of Grand Ronde have 100% unmet need status defined by Indian Health Service Resource Requirement Methodology (RPM) formula. The RPM method is the sole mechanism for developing the health service priority system rankings which would determine allocations made through the Indian Health Care Improvement Fund.

The Confederated Tribes of Grand Ronde endorses the testimony submitted by the Northwest Portland Area Indian Health Board and wish to go on record with this written testimony.

Sincerely,

Kathryn Harrison

Kathryn Harrison
Tribal Chairperson

PREPARED STATEMENT OF THE DALLAS INTER-TRIBAL, INC., SUBMITTED BY DEANNA CHESHEWALLA, CHAIRPERSON, BOARD OF DIRECTORS

My name is Deanna Cheshewalla. I am the chairperson of the board of directors of the Dallas Inter-Tribal Center, Inc., a comprehensive urban Indian health organization incorporated in 1971, to address the health needs of the 20,000 Indians living in Dallas and the surrounding 11 county area.

I am submitting this written testimony to urge the reauthorization of bill S-277 (The Indian Health Care Improvement Act) and for continued appropriations for urban Indian health care. In 1964, Congress, as a matter of public policy, declared this nation's intent to "eliminate poverty in the midst of plenty." In 1976, Congress passed the above mentioned act. In 1980, this act was reauthorized and it reaffirmed the government's commitment to help Indians, whether on reservations or in urban areas (Title V of the Act), to acquire health care that would eventually allow them to obtain a health status on a parity with the general American population. Even though this bill passed both houses of Congress in 1985, it was vetoed by the President. However, through the Continuing Resolution, these urban Indian health programs are funded through September, 1985. These declarations recognized that poverty and ill health are in concert and that national effort must be undertaken to eradicate both if Native American Indians are to improve the quality of their existence and to gain access to the abundant prosperity generally available to the U.S. population. While progress has been made (dramatic declines have been reported in the incidence of tuberculosis, infant mortality, chronic anemia, and malnutrition), still a disproportionate number of Indian people suffer from diabetes; heart disease; high blood pressure; upper respiratory infections, such as ear infections, colds and flu; and from dental problems. Studies continue to report the Native American Indian, based on any measure of income, educational attainment, employment, housing conditions, or health status is the most isolated, underserved, and deprived group in this country.

Texas, according to the 1980 Census, has an Indian population of 40,440. In 1970, the Census reports 17,957. Texas Indian communities estimate closer to 70,000, unofficially. Whatever the actual figures, Texas has the ninth largest Indian population in the United States. This state has two reservations. But these reservations, which are only state recognized, are home for only 859 or 2.1% of the state's Indians. Most live in cities or rural areas. The Dallas/Fort Worth area is home to approximately 20,000 or 49.5% of these off-reservation Indians. A survey completed by this center in 1977-78 showed that 48.2% of the area Indian population has migrated here since 1957, when the Bureau of Indian Affairs opened a field employment placement office in Dallas. While that office closed in September, 1980, Indian people continue to migrate to the Dallas area.

Data taken from a status report done by the Texas Indian Commission in 1983, shows the following statistics for the Dallas/Fort Worth metroplex Indian community: The average family size is 3.9, the median family income is $7,000 annually, 53% of the population is at or below poverty level, 45.6% of the population is unemployed, 25% of the population lives in substandard housing, and the median education level is 11.2 years. Of 1984 Dallas Inter-Tribal Center medical users, 65.7% are under 20 years of age, 21.4% are 20-34, 5.6% are 35-64, and .8% are 65 years old or older. In 1984, 2,835 new patients were seen in our medical and dental clinics.

For Dallas area Indians, the essential support system used in making the difficult transition from reservation to urban life is the Dallas Inter-Tribal Center. This program is the "safety net" for these people.

Since 1971, the Dallas Inter-Tribal Center, Inc., has made a determined effort to mitigate the barriers that keep Indians from receiving social, economic, employment, educational, and health services in the city. While primarily funded to provide ambulatory health care services, the center recognizes that the absence of disease or infirmity does not, in itself, constitute a healthy person or population. Health is also a state of social and economic well being. Most of the clients who use the center are also suffering the consequences of legal disfranchisement and other problems arising out of the social fabric of the environment. Burdened with the inability to cope with feelings of hopelessness and despair, dependence and inferiority, the urban Indian is not as well prepared psychologically or vocationally for existence in the urban oriented 20th Century as is the general population. This quality of life carries over directly into a disproportionate amount of emotional and health problems such as depression, personality disorganization, alcoholism, suicide, and disease.

The proper approach in attacking these problems involves more than medical treatment of the symptoms. Because the roots of these problems are in the complex interaction of biological, social, cultural, and environmental factors, the solutions cannot be approached in a narrow technological way, but require a health system which can provide human support in other areas as well.

Through its programs, the Dallas Inter-Tribal Center attempts to erase the painful and difficult transition from endless years of reservation dependence to life in the city. Those services include medical, dental, health/nutrition education, WIC, eyeglasses and clothing services, transportation, referrals, medical follow-up, alcoholism counseling, Indian child welfare services, and home visits.

% Services Increase/Decrease
%IHS Funding Increase/Decrease

Year	% Service +/-	% IHS Funding +/-
1979-1980	+ 75.2%	+ 10.1%
1980-1981	+ 69.0%	+ 11.1%
1981-1982	+ 5.0%	+ 2.0%
1982-1983	+ 36.7%	- 13.1%
1983-1984	+ 2.0%	+ 3.7%
1974-1984	+802.3%	+356.4%

The success of the Dallas Inter-Tribal Center in impacting the severity of these problems, the recognition that the services are cost effective ($14.26 per encounter compared to $40-$45 in the private sector), the realization by other human service providers that only the Dallas Inter-Tribal Center can effectively address this need for Indian people in Dallas, and that city and state resources are unable to absorb costs for these services are all documented in our reports to our funding agencies.

Without Title V dollars for health care, Indians will have to return to the reservations for care. In Dallas, private physicians refuse to see clients on medicaid because the reimbursement rate does not reasonably cover costs. The city claims it does not have revenue to absorb the loss in federal support to community health centers and the state believes that it must maintain those programs it already supports through the block grant plan. Reservations, already overburdened, are not accessible, the closest PHS-IHS hospital being in Lawton, Oklahoma, approximately 200 miles away. In region seven, the four urban Indian health programs have submitted over 200 applications to the private sector and private foundations for health care funding support. Not one application has received an affirmative response. There just are no alternatives to the maintenance of the federal support for urban Indian health care at this time.

The Dallas Inter-Tribal Center has received health care dollars from Indian Health Service since 1974. From that period to 1984, the services have increased by 802.3%, while IHS funding increased by only 356.4%. From 1980 through 1984, services increased by 147.4%, while IHS funds remained essentially the same.

This adminstration has proposed the "safety net" theory in the belief that the underprivileged should not suffer unfairly in the cutting of waste in the government programs. This concept must include Title V funding programs for two reasons: (1) It is more cost effective to maintain this proven system for health care delivery than to disrupt that system, in so doing, to create an additional burden on local health services when those resources are also being cut back under block grants and medicaid. (2) It is more humane to maintain the gradual improvement in the health of the Indian population than to lose those gains immediately, and then, in the future, have to develop yet another system when it is clear that the local resources cannot absorb the demand for such care.

If the "safety net" theory is to be protective and supportive of Indian people, then the President and Congress must clearly understand: That an Indian continues to struggle to acquire basic human needs satisfaction (biological and psychological: safety, food, housing, employment, acceptance) while the majority of the population has already acquired those basics and is directed towards the more human pursuits (personal growth, meaningfulness, competence, advancement, self-actualization): that this country, which holds out to the world its benevolence, must, as a society, also foster the fullest development of human potentials for all its own peoples.

The paradox of Indian poverty and ill-health in the midst of plenty is a travesty. The Indian has briefly and barely tasted some of the fruits of this abundance, but will not easily return to a fruitless existence. When you are at the bottom of the totem pole, there can be no way but up. To expect the Indian to be satisfied with less is wholly unreasonable in the 20th Century.

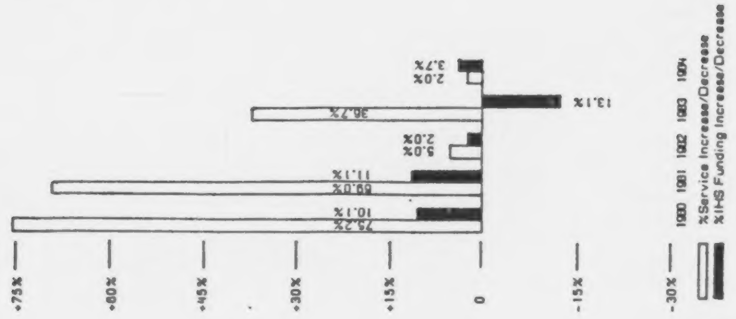
Without continued federal support to provide access to better health care and therefore a better life, the urban Indian truly remains the unwilling prisoner of an inhumane society.

I urge you, in the interests of this country and the people I represent, to continue the improving relationships between the government and the Indian by remaining directly involved and responsible for the provision of health care and other desperately needed support services so that the First Americans can also become first class Americans with all that entails.

You can accomplish this by reauthorizing the Indian Health Care Improvement Act and appropriating $12 million for urban Indian health programs.

Thank you.

Deanna Cheshewalla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%Service Increase/Decrease
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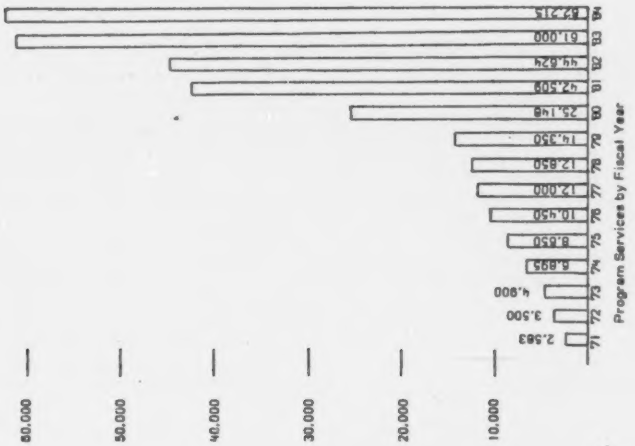
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4,800
6,895
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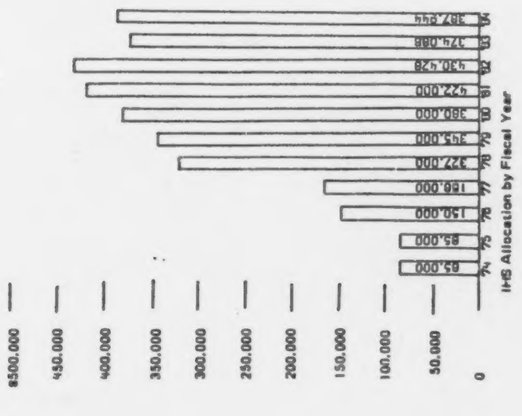
Program Services by Fiscal Year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84
85,000
85,000
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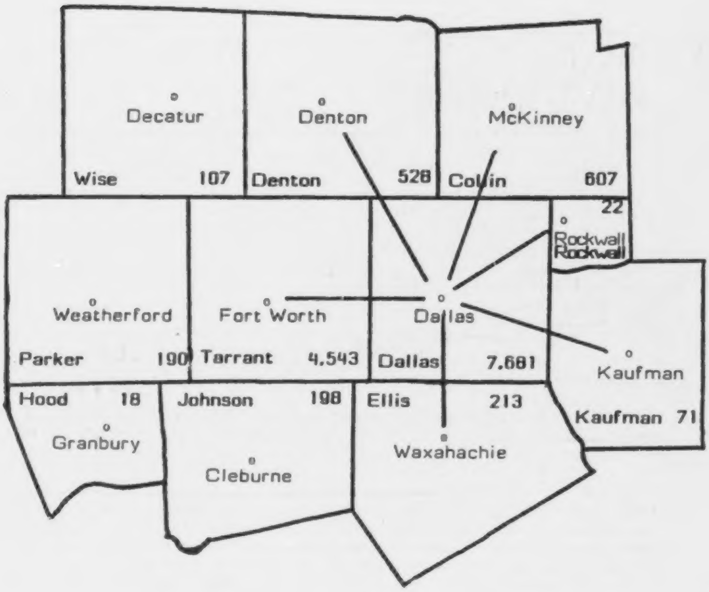
327,000
345,000
380,000
422,000
430,428
374,088
387,044
IHS Allocation by Fiscal Year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Wise 107
Denton
Denton 528
McKinney
Collin 607
Rockwall
Rockwall
22
Weatherford
Parker 190
Fort Worth
Tarrant 4,543
Dallas
Dallas 7,681
Kaufman
Kaufman 71
Hood 18
Granbury
Johnson 198
Cleburne
Ellis 213
Waxahachie

DALLAS INTER-TRIBAL CENTER
CATCHMENT AREA

Figures are taken from the 1980 Census of Population and Housing. Total 14,178

RECEIVED FEB 05 1985

FCNL
FRIENDS COMMITTEE ON NATIONAL LEGISLATION
245 Second St. NE, Washington, DC 20002
(202)547-6000 Office
(202)547-4343 Update Tape

January 30, 1985

Senator Mark Andrews
United States Senate
Washington, DC 20510

Dear Senator Andrews:

The Friends Committee on National Legislation would like to thank you for your introduction of S. 277, the "Indian Health Care Amendments of 1985," on January 24.

In our work to support the rights of Indian people, the continuation of health services to American Indians and Alaska Natives is a top priority of the Friends Committee on National Legislation in the 99th Congress. As you are, we are eager to see Congress adopt such a reauthorization bill, and hope S. 277 can be enacted quickly to ensure a constant delivery of vital health services to reservation and urban Indian communities.

We are grateful for your able and faithful leadership on this issue and so many others which affect this country's first Americans.

With best wishes in the new year,

Cindy Darcy
Legislative Advocate
Native American Affairs

Walter E. Schutt *Clerk, General Committee* Lilian Watford *Clerk, Executive Committee* E. Raymond Wilson *Executive Secretary Emeritus*
Edward F. Snyder *Executive Secretary* Ruth Flower *Legislative Secretary* Nancy L. Alexander *Legislative Secretary*
Alison D. Oldham *Legislative Action Coordinator* Selig Goodman *Development Secretary*
Wilton E. Hartzler *Associate Secretary for Administration*

COUNTY OF HILL
STATE OF MONTANA
Havre, Montana 59501

Arthur Rambo, **Chairman**
A. R. Hagener, **Commissioner**
Leroy Keller, **Commissioner**
[406]265-5481 Ext. 27

March 11, 1985

Senator John Melcher
United States Senate
730 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Melcher:

Thank you so much for your presentation and discussion on the IHS bill and indigent care issue at the NACo meetings. Our Montana delegation was most pleased with your willingness to meet with the committees. I am sure that your appearance impressed the other county members as well.

"Our" resolution passed both committees but was not acted upon by the NACo Board of Directors due to the number of resolutions and urgency of action on other issues.

Your question regarding hospital costs is being researched by Carole Graham. I am attaching two exerpts from our MACo newsletter that may be of interest to you.

A point tangentially touched upon at the hearing was that for the IHS to be the primary provider "would cost the government too much". Since these costs were covered up until three years ago it would seem that there would be only minimal changes in cost. Shifting the cost to counties would certainly cost individual county governments "too much". While the IHS appears to have the option of shifting costs, County governments and local providers do not.

The problem may be more acute in Montana because of the heavy reliance on property tax, but the concern for any cost shifting is a major one for all counties.

Thank you again for your help on all of Montana concerns!

Sincerely,

A. R. (Toni) Hagener
Hill County Commissioner
Member, NACo Health and Education
Steering Committee

ARH/tb

EXCERPTS FROM THE MONTANA ASSOCIATION OF COUNTIES NEWSLETTER
VOL. 14, NO. 3 MARCH 1985

LAWSUIT

The Montana Hospital Association has selected Northern Montana Hospital in Havre to bring suit on behalf of all hospitals in the State, on the issue of payment for hospital care for indigents. The suit is directed at Blaine County, but the outcome will affect all counties.

The suit is filed to recover the difference between the amount charged by the hospital and the amount paid by the county for hospital services for indigent people. Bruce Moerer, deputy Blaine County attorney said that over the past three years, the total difference is almost $17,000. In Hill County, the difference is about $80,000.

Blaine County did not pay the amount charged by the hospital, but paid for the services at the current Medicade rate, as authorized by law under Sec. 53-3-301, MCA.

Because of the far-reaching effects of this lawsuit, Moerer said he would like the assistance of other counties and their county attorneys, as intervenors or by submission of amicus briefs.

INDIAN COUNTIES

The MACo Indian Counties met in Helena Feb. 13 during the Midwinter Meeting, and endorsed a resolution asking Congress to increase funding of the Indian Health Service program and to adequately reimburse counties and local health facilities for treatment of medically indigent individuals who are enrolled members of Indian tribes.

The group expressed support for Sen. John Melcher's magistrate legislation, and identified policy objectives, which are to lobby Congress when necessary, get the federal government to fulfill its trust responsibilities to the tribes, to limit tribal taxing jurisdiction, to clarify the court system, and to obtain increased funding for health care.

Glacier County commissioner Fred Johnson chaired the meeting, and introduced William Coldiron, former solicitor for Dept. of Interior Secretary James Watt. Coldiron said that Congress is the best place to resolve problems such as jurisdiction on the reservations, rather than through the Courts, although a good test case would be beneficial in clearing up some grey areas.

He urged the group to "get their act together" and present some proposals to Congress, preferably by working with other groups and through the Congressional delegation.

Betty Cerovski, field representative for Sen. Melcher, was present at the meeting.

PREPARED STATEMENT OF ELIZABETH YELLOW BIRD DEMARAY, ASSISTANT DIRECTOR, INDIANS INTO MEDICINE PROGRAM, UND SCHOOL OF MEDICINE GRAND FORKS, ND

I had intended to present this information as oral testimony. However, the weather in the midwest stopped all flights and I was unable to rebook.

The format of the written testimony is attached at the end. Please excuse this but I feel the impact of the statement is better retained this way. The strengths and accomplishments of INMED are in the other section but related important concerns are as follow; some speak to medicine in general but the implications are strong for health manpower needs of Indian people:

1. Student financial aid cutback has reached a crisis in the U.S. in all arenas - the Indian students are hurt most because of their poverty backgrounds and lack of resources for which they may support their education. The upper-class, higher-income students we have seen, know the systems better and are able to get the extra financial support, while the poorer students are left to live on loans. President Reagan recently suggested a $4,000.00 total cap on federal financial aid. This could eliminate the poor student from higher education. The out-of-state tuition alone at U.N.D. has been raised to $3,000.00/year for undergraduates. For medical schools, tuitions range from $3,164.00 for residents to $6,154.00 for non-residents at U.N.D. and up to $3,000.00 for out-of-state in Colorado with an average of $9,000.00. We also have seen many talented Indian students coming from foster homes who need financial support. Eighty-nine percent of new physicians graduating from Med School are in debt; owing an average of $29,000.00 in student loans which does not include undergraduate loans. We are also seeing older students who have college age students themselves; they will have to choose who attends college.
2. The GMENAC (Graduate Medical Education National Adviosry Committee) report, which spoke to the over supply of physicians concluded there will

a continued uneveness in the geographic distribution of physicians. The Aberdeen area is only four doctors short compared to the severe shortages in the past. However, there is still concern regarding the overload of patients, and the length of stay of these doctors. In a Billings area clinic there are three permanent doctors and one temporary doctor who are seeing an average of 100 patients per day.

These IHS doctors are treating more patients with serious chronic diseases, and does more mental health work and alcoholism counseling than regular family physicians. The reservations and other rural areas need doctors who can handle these probelms without being able to refer to specialist easily. Of the 13 residents of the INMED Program, 75% are in primary care specialties to meet this need.

3. The GMENAC did not consider the life style issue. Most physicians are not willing to work the 80 hours plus, work week. The doctors are being made aware of burnout and impaired physician problems and are encouraged to decrease the amount of hours per week worked. A study published in the December issue of the American Journal of Public Health has been done which found that the length of the physicians work week has diminished by approximately 1.5 hours per week or roughly 3%. Soon three physicians may be required to replace two if the desired balance in lifestyle is to be achieved. The turnover at IHS sites shows what happens when more balance can not be achieved.
4. Solo practice appears to be fading. Instead of one physicians, two or more in group practice appears to be evolving as the rule
5. Many more physicians today are married to spouses who want an equal career opportunity. This need alone could preclude the choice of a practice in a rural isolated area. This is continually happening at reser

vation areas, the spouse many times can make or break the situation.

6. GMENAC also did not consider the change in physician attitudes in relation to the utilization of referral and other supportive services. Today's Family Physician is trained in a setting where both consultation and referral are readily available. These doctors have developed practice patterns which integrate utilization of specialists. Greater demand for specialists than that projected by GMENAC, therefore, may be the result. Conversely, the turnover of physicians in IHS will increase as physicians feel less able to work without specialty backup readily available.
7. Changes in the reimbursement system, additionally, may impact greatly on physician numbers and distribution. The Prospective Payment System, which uses the diagnostic related groups (DRGs), for example, did not exist when GMENAC did its work. The DRC Program already is forcing medicine to examine its methods and styles of practice.

Beyond the DRGs, cost containment strategies are being studied and proposed at every level of government and by professional associations throughout the country. The economics of health care delivery are important to both the provider and the consumer of services and will exert increasing influence on the physician of the future. Numbers of patients and physicians alone are misleading. This area is very complex.

INDIANS INTO MEDICINE
INMED
UND SCHOOL OF MEDICINE
501 N. COLUMBIA ROAD
GRAND FORKS, ND 58201
(701) 777-3037

TO:	United States Senate Select Committee on Indian Affairs Washington, D.C. 20510
FROM:	Indians Into Medicine Program (INMED) School of Medicine University of North Dakota Grand Forks, ND 58201
HEARING DATE:	March 6, 1985
WITNESS:	Elizabeth Yellow Bird Demaray, Assistant Director Indians Into Medicine Program (INMED) 501 North Columbia Road Grand Forks, ND 58201

I am here on behalf of the Indians Into Medicine Program and its tribally-appointed Advisory Board to request your continued support of INMED and the Indian health manpower scholarship program. Our request is for INMED to remain a line item in the Indian Health Service budget, and for the United States Congress to reauthorize the Indian Health Care Improvement Act during this year's sessions.

Thank you for the opportunity to appear before you. My name is Elizabeth Yellow Bird Demaray. I am Assistant Director of the Indians Into Medicine Program at the University of North Dakota School of Medicine.

I am here as a representative of INMED, and the tribally-appointed INMED Advisory Board with delegates representing 22 reservations. I am here to request your support for reauthorization of Public Law 94-437 and continuation of INMED as a line item within the Indian Health Service budget as we have been the most successful program of this type.

The Indian Health Care Improvement Act, Title I, is the most concrete implementation of the federal government's commitment to bring the numbers of American Indian/Alaska Native health professionals closer to parity with the percentage of health professionals within the general population. Great strides have been made. In 1972 when the INMED Program came into existence, there were 40 Indian physicians in the United States identified as Native American. There are currently between 240 and 311 identified Indian medical doctors, 38 of whom have graduated through the INMED Program alone. We have also graduated nine allied health professionals. Currently INMED has 25 more students in medical school. We also support 50 undergraduates, and from 60 to 100 summer students, some of whom are supported through the Health Careers Opportunity Program.

Using medical doctors as an example, the parity situation is improving, but gains in the numbers of Indian health professionals thus far are only the "tip of the iceberg". The vacancy list at IHS facilities are not as long as they were a decade ago, but the INMED philosophy of "providing Indian health professionals to meet Indian health needs" rings true today. Indian health professionals will more likely make Indian health care a career. Permanent placement at an IHS site will enable physicians to provide a level of concern and continuity in patient care which is impossible for transient health professional detailed to IHS facilities to achieve. The Indian Health Service's priority placement of its scholarship graduates should guarantee that Indian health professionals have an opportunity to practice among Indian people; although some Indian health professionals continue to face bureaucratic barbed wire as they attempt to attain placement suitable to themselves and IHS.

INMED, which served as a prototype in the development of sections 102-105 of Indian Health Care Improvement Act, Title I, is the most successful program funded through the Act.

IHS has recently placed emphasis on the field of nursing, in line with section 103 and 104 scholarship program guidelines. The INMED Program had no students enrolled in nursing curriculum in 1980. For the 1984-85 school year, INMED provides full support for 17 nursing and pre-nursing students, and counseling and academic assistance for another seven. This is indication of INMED's ability to meet changing Indian health manpower needs.

For the 1984-85 school year, the 14 scholarship area offices administer a total of 106 section 104 scholarships for medical students. Twenty, or roughly, one fourth of these scholarships were awarded through the INMED Program. INMED now has six more medical students that do not receive IHS scholarships for a total of 26 medical students.

An important part of Senate Bill 277 to reauthorize the Indian Health Care Improvement Act is Section 107(b)(2), which will remove the four-year maximum eligibility limit on Section 104 scholarships for health professions students. Several INMED medical students in good standing face termination of their scholarships because of the four-year limit. These students are progressing toward their degrees, and they will willingly accept year-for-year service payback obligations for continued support. The cost of medical education are increasing. These students are applying for Title IV and other scholarship programs but the one that did last year was unsuccessful. The IHS scholarship program seems to be their only hope to achieve a medical career.

We at the INMED Program appreciate the support the United States Congress has provided for Indian health manpower development, and we encourage a prompt reauthorization of the Indian Health Care Improvement Act through Senate Bill 277 to assure uninterrupted student support.

INDIANS INTO MEDICINE PROGRAM FACT SHEET

INMED has assisted Indian health professionals educationally, including 38 physicians, one dentist, two Masters of Public Health, two bachelor degree registered nurses, one physical therapist, one medical technologist, and two health educators.

During the 1984-85 school year, INMED is providing financial, academic, and personal support for 23 pre-professional students, and 28 professional students in medical, nursing, and medical technology schools. INMED has enrolled over 200 students in pre-professional academic curricula since 1973.

INMED has organized and implemented a Summer Institute for high school and college students each year since 1973. Over 200 complete applications have been received annually for the 20 to 70 available positions. To date the total enrollment in Summer Institute is 516.

INMED is governed by an all-Indian Advisory Board of tribal appointees representing 23 tribes in INMED's service area (North Dakota, South Dakota, Wyoming, Montana and Nebraska), plus several charter members. This Board has provided direction, policies, and priorities to the INMED Program continuously since 1974. This Advisory Board is INMED's linkage to the wishes, needs, and resources of the 100,000 Indian people in the INMED service area.

INMED has an overall retention rate of 80% for the pre-professional students and 95% for professional students. The national drop-out rate for Indian medical students is estimated to be 12%, or 88% retention rate; while the Indian college student retention rate is about 50%. INMED staff has provided yearly over 900 hours of tutoring and 3500 hours of academic, financial, and personal counseling as part of INMED's extensive support services system.

INMED staff uses telephone, written communication, and personal visits to make over 13,000 contacts annually with Indian students, parents, tribal officials, counselors and others. These contacts are to increase the interest, awareness, and motivation of Indians toward the health professions, and also to retain participating students in their curriculums.

Since 1973, INMED has produced numerous motivational publications, including a color book, a paper doll book, two volumes of physicians' biographies, a health career game, posters, and a recruitment comic book. The program has also produced audio-visual materials, including program presentations, teaching video tapes on genetic counseling and photodermatitis, a puppet "health career" education show, and a video tape entitled the "Red Medicine Road". INMED staff are currently developing an 80-page motivational book entitled "Medicine Women".

INMED has produced thirteen workshops addressing such Indian health issues as alcoholism, tuberculosis, traditional medicine, health career education, diabetes, domestic violence, health manpower training, and hypertension.

Through the program's offices in the School of Medicine, INMED's formal linkages at the University of North Dakota have expanded to include working with the departments of Medical Technology, Nursing, Physical Therapy, and Clinical Psychology. INMED is also involved in developing programs to sensitize the nursing staff and students to the culture and needs unique to INMED people.

INMED staff and students have participated in the planning and implementation of all Indian social and cultural activities on the University of North Dakota campus annually.

The University of Manitoba, Winnipeg School of Medicine, and the Coordinator of Native Health Care Development for Health, Welfare, Canada, have visited the Program and used INMED as a prototype for projects they are developing. The Program has also been studied by a representative of the University of Newcastle Medical School, South Wales, Australia. It is a showcase for the nation.

The INMED director assisted the UND School of Medicine and Indian Health Service in developing educational and clinical programs on INMED service area reservations.

INMED has aided reservations in the research on health issues on the local, as well as national levels.

Six issues per year of the INMED newsletter, Serpent, Staff & Drum are distributed to approximately 500 individuals and organizations interested in Indian health care and education.

In 1983, one graduating INMED physician scored in the 95% on National Medical Boards II. Combined with his 99% on Boards I, this student was in the 97% nationally for graduating physicians. In 1983, he also received the H.J. Kaiser Award for outstanding academic achievement nationally by a minority medical student. He is currently practicing at his home reservation.

INMED placed three special graduates with the National Institute of Health Summer Development Program for summer 1983. One special graduate in the National Institute of Health Carcinogenic Research Laboratory for a one year appointment; and a 1985 medical student for summer research at the N.I.H. Bethesda, MD laboratory. This winter another first year medical student was selected to attend the mid-winter workshop at N.I.H.

Three Indian medical graduates began residency programs in North Dakota during Summer, 1984. Others started in Michigan, New Mexico and Oklahoma.

An INMED medical graduate in 1984 received the first Mead-Johnson Young Investigator award to finance her continued cancer research. She now is on staff at Mid-Dakota Clinic in Bismarck where she is consulting oncologist for surrounding Indian reservations.

During 1984 and 1985, INMED has been studied by the UND Department of Aviation and Law School for the development of their Indian Student Support Programs.

Since 1982, INMED has operated a short-term student loan fund, developed and supported by the Program's Indian Advisory Board. The Advisory Board has also developed an Art Auction to help raise money for emergency student needs.

June 1, 1983
Kerry Hartman

Revised February 28, 1985
Jim Beiswenger

MDs' hours are longest among the self-employe

Physicians work more hours than do other self-employed individuals, according to a study by the American Medical Association Center for Health Policy Research.

Self-employed individuals generally work more hours than do wage and salary workers, yet an analysis of office-based physicians' typical work week from 1970 to 1980 found that — in 1979, for example — office-based patient-care MDs worked an average of 49.7 hours a week, nearly eight hours more than did other self-employed people.

Although physicians' work weeks are long, they are not as long as they used to be. The study found that the length of their work weeks has diminished by approximately 1.5 hours per week — or roughly 3% — a statistically significant amount.

Hours of work are greatest early in a physician's career, the study found. The number of hours worked weekly declines slightly over the years until age 65, when they fall off sharply.

HOWEVER, FEMALE physicians were an exception to this overall pattern. Unlike their male counterparts, whose hours of work declined over the decade studied, female physicians actually increased their work week by 1.8 hours over the course of the decade.

Graduates of foreign medical schools also increased their work week, by 1.1 hours. Graduates of U.S. schools followed the overall trend.

Solo practitioners decreased their work weeks by 2.4 hours over the decade, while group practitioners decreased theirs by only 1.7 hours. General and family practitioners decreased their work weeks by 3.7 hours, while surgeons decreased their work weeks by only 1.1 hours. Urban physicians cut their work loads by 1.2 hours weekly, while non-urban physicians cut 2.5 hours a week from their work loads.

The study also found that physicians increased their overall average percentage of hours spent in patient care from 87.7% to 90.8% of hours worked. This led AMA economists Marc P. Freiman and William D. Marder, who conducted the study, to conclude that the practice of medicine has become more efficient during the decade. "Compared to 1970, physicians in 1980 were spending more time doing what they learned in medical school and less time on the non-medical aspects of practice," they said.

IF THEY CONTINUE, these trends will have implications for the future supply of physicians, say Freiman and Marder in an article published in the December issue of the *American Journal of Public Health.* A decline of 3% in the hours worked by physicians is equivalent to a reduction of 8,000 patient-care physicians, they say — equivalent to 50% of one graduating class of all U.S. medical schools.

Noting that studies such as the often-cited report of the Graduate Medical Education National Advisory Committee (GMENAC) have projected an MD surplus of 70,000 by the year 1990, Freiman and Marder say, "A decline of only a few hours per week in the time spent by physicians in patient care would eliminate much of this surplus."

Forecasts such as those of GMENAC do not explicitly take into account potential shifts in the flow of services provided by future physicians, the economists say, nor do some projections of the future costs of medical care.

Pointing to the decline in hours worked by primary-care physicians over the decade, and speculating that the decline may have been a result of increasing competition, the economists suggest that increasing competetive pressures, caused by the expanding supply of physicians, "will provide further impetus over the next decade for physicians to trade off more leisure-time activity against time delivering medical services."

LUMMI INDIAN BUSINESS COUNCIL
2616 KWINA RD. • BELLINGHAM, WASHINGTON 98226-9298 • (206) 734-8180

DEPARTMENT: ______________ EXT ______

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Councilman

March 5, 1985

Senator Mark Andrews
Chairman
Senate Select Committee on Indian Affairs
838 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Andrews:

As Chairman of the Lummi Indian Tribe of the Northwest Coast, [illegible]mmend this Committee in its work on S. 277, "Indian Health Care Improvem[illegible] Act Reauthorization" and your initial hearing March 6. I submit this le[illegible]r as testimony for the hearing record on the singular issue of American Indian youth.

The future of the Lummi Tribe, as all other Tribes, depends on its youth and their physical/social development. Over half the population of the Lummi Tribe is under the age of 18 years. With this sizeable population emerging into the complex pressures of the Indian and non-Indian world, we are extremely concerned that minimal to non-existent assistance is available for American Indian youth prevention and diversion programs.

The social and health needs of American Indian youth have been virtually lost in the bureaucratic shuffle. In our review of available Federal assistance for juvenile populations, Tribes have been excluded in the new Federalism concept of block grant funding to States.

Let me provide some blatant examples:

1. The Office of Juvenile Justice and Delinquency Prevention in the Department of Justice block grants almost all its funds to States. No funding is available for Tribal programs.

2. The National Institute of Drug Abuse and Mental Health of the Public Health Service block grants almost all its funded to States. No funding is available for Tribal programs.

3. The social services block grant program of the Department of Health and Human Services sends block grants to States with minimal assistance available to Tribes.

4. The Indian Health Service alcoholism program concentrates on treatment with a low priority afforded prevention programs.

American Indian youth, growing up in both the Indian and non-Indian societies, are particularly susceptible to social pressures in the delicate adjustment period of adolescence. Targeted assistance to provide support and guidance in the formative years of adolescence are of critical importance to individual and Tribal futures.

The Indian Health Care Improvement Act appears to be the most logical legislative initiative available to address the social and health needs of this Indian population group. I strongly urge this committee, the Congress, and Indian Nations to seriously consider the enclosed provisions of H.R. 1156, "Indian Juvenile Alcohol and Drug Abuse Prevention Act" introduced by Congressman Bereuter and Daschle on February 20, 1985. The legislation should be expanded to provide Tribes with assistance for delinquency diversion and prevention focusing on the many positive dimensions of growing up as American Indians in modern society.

The Indian Health Care Improvement Act reauthorization should broadly assist Tribes in strengthening the family. The family unit is the singularily most important element in Tribal societies providing the framework for healthy child development and adult living. Pressures disintegrating the family have left their scars on Indian people. Support for child and family services should be an integral theme to the Indian Health Care Improvement Act.

Sincerely,

Larry G. Kinley

Larry G. Kinley
Chairman

Enclosure

MONTEREY COUNTY

THE BOARD OF SUPERVISORS

1850

THE COURTHOUSE - 240 CHURCH STREET - P.O. BOX 1004 - SALINAS, CA 93902

BARBARA SHIPNUCK
SUPERVISOR - DISTRICT 2

SUSAN WEST
AIDE TO THE SUPERVISOR

424-8611, EXT. [illegible]

March 12, 1985

The Honorable John Melcher
United States Senate
Hart Senate Office Building, Room 730
Washington, D.C. 20510

Dear Senator Melcher:

As a member of the National Association of Counties Health and Education Steering Committee and Chair of the Subcommittee on Primary/Preventive and Mental Health I am appreciative of your appearance before the Committee. The resolution on Indian Health Services Legislation which the Committee passed and I supported will have impacts on delivery of health services at the local level. This type of cooperation among federal, state and local jurisdictions will enhance the quality of health services we can provide to our constituents.

Thank you for bringing this issue before NACo. I hope we will have future occasions when NACo can work with Congress in support of needed legislation coming out of the Select Committee on Indian Affairs.

Sincerely,

Barbara Shipnuck
Chair, National Association of Counties
Primary/Preventive and Mental Health Subcommittee
Chair, County Supervisors Association of California
Health and Welfare Committee

BS:sw

NATIONAL
ASSOCIATION
of
COUNTIES

440 First St. NW, Washington, DC 20001
202/393-6226

March 1, 1985

RECEIVED MAR 0 4 1985

The Honorable Mark Andrews, Chairman
United States Senate
Select Committee on Indian Affairs
724 Hart Senate Office Building
Washington, D.C 20510

Dear Senator Andrews:

Thank you for providing our association with an opportunity to testify on S. 277, a bill to reauthorize the Indian Health Care Improvement Act of 1976. NACo is very concerned about the issue of health care for indigent individuals. As part of this concern, we are currently examining the issue of the Indian Health Service as a residual provider of health care to Indian people.

At the present time, we have not adopted any policies specifically applicable to this issue. However, we expect the NACo Health and Education Steering Committee to consider proposals to adopt policy in this area within the next week. Unfortunately, because we will not have specific policy on this issue, we will be unable to testify by March 6, but look forward to doing so in the future. I will forward to you any newly adopted NACo policy on the subject promptly, so that it can receive the fullest consideration of the Select Committee on Indian Affairs.

Thank you for your interest in the Indian Health Service and in the role of counties in providing health care. I look forward to working with you in the future.

Sincerely,

Philip B. Elfstrom

Philip B. Elfstrom
President

PBE:gfw

AMERICA'S
COUNTIES
150 Years of Service to People

Nez Perce
TRIBAL EXECUTIVE COMMITTEE
[redacted] (208) 843-2253

March 22, 1985

Chairman
Select Committee On Indian Affairs
United States Senate
Washington, D.C. 20510

Dear Sir:

Please insert the attached Resolution NP 85-168 for the record and insupport of the legislation for the Reauthorization Of The Indian Health Care Improvement Act.

We wish to thank the Committee in allowing us the opportunity to present oral testimony to support S-277.

Sincerely Yours,

Allen P. Slickpoo Sr.
SECRETARY

Enclosure: Resolution NP 85-168

NP 85-163

RESOLUTION

WHEREAS, the Nez Perce Tribal Executive Committee has been empowered to act for and in behalf of the Nez Perce Tribe, pursuant to the Revised Constitution and By-Laws, adopted by the General Council of the Nez Perce Tribe, on May 6, 1961 and approved by the Acting Commissioner of Indian Affairs on June 27, 1961; and

WHEREAS, the Nez Perce Tribe has been designated as an "affected Tribe" under the Nuclear Waste Policy Act of 1982, because of the Hanford Nuclear Repository site selection recommended; and

WHEREAS, the Nez Perce Tribe in consideration thereof, has become vitally concerned as to any health hazards maybe posed by potential continuation of Nuclear Waste; and

WHEREAS, the 99th Congressional under consideration S-277 to reauthorize and amend the Indian Health Care Improvement Act, wherein it has been proposed to include provisions for nuclear resource development related health problems including preventive care for Indians who may be exposed to such health hazards that any result from such nuclear resource developments.

NOW, THEREFORE, BE IT RESOLVED, that the Nez Perce Tribal Executive Committee, as being located with geographic proximity to Nuclear Waste sites, at Hanford, Washington, supports the enactment of S-277.

BE IT FURTHER RESOLVED, that the Nez Perce Tribal Executive Committee urges the Congressional delegations to give favorable consideration and support to S-277.

CERTIFICATION

The foregoing resolution was duly adopted by the Nez Perce Tribal Executive Committee meeting in Regular Session, February 12, 13, 14, 15, 1985, in the Richard A. Halfmoon Council Chambers, Lapwai, Idaho, a quorum of its Members being present and voting.

BY: ______________________
Allen P. Slickpoo, Sr., Secretary

ATTEST:

Herman Reuben
J. Herman Reuben, Vice-Chairman

North Slope Borough
Health and Social Services
Agency

Box 69
Barrow, Alaska 99723

(907) 852-3999
(907) 852-3065

RECEIVED APR 0 5 1985

April 5, 1985

Senator Mark Andrews, Chairman
Senate Select Committee on Indian Affairs
United States Senate
Washington, D.C. 20510

Ref: The Indian Health Care Act: S.277

Dear Senator Andrews:

The North Slope Borough goes on record as supporting the Indian Health Care Act S.277 and urges Congress to pass this legislation for its insight and long-term perspective on Native Health Care as exemplified: i.e. by recruiting and providing scholarship funds to assist our youth in health professions including continued education opportunities for the Community Health Representatives (Title I); emphasizing the importance of health promotion and disease prevention (Title II); as well as educating our youth within the school systems to the hazards of alcohol and drug abuse with its crippling effects on family and community (Title VII).

Thank you.

Respectfully,

Michael R. Stackhouse

Michael R. Stackhouse, Director
North Slope Borough Health and Social Services Agency

MRS:awe

LAC COURTE OREILLES
TRIBAL GOVERNING BOARD

Pride Of the Ojibwa
Route 2 • Box 2700
Hayward, Wisconsin 54843
(715)634-8934

1985 APR 22 AM 10 46

April 12. 1985

Senator Mark Andrews
Chairman
United States Senate
Select Committee on Indian Affairs
Washington, D.C. 20510

Dear Chairman Andrews:

This letter is in response to your letter of March 15, 1985 requesting written testimony pursuant to Senate Bill 277 the Reauthorization of the Indian Health Care Improvement Act of 1976. I am submitting this written testimony for the record as instructed per your correspondence.

The reauthorization of the Indian Health Care Improvement Act is, in my opinion, important both to the Lac Courte Oreilles Tribe and all Indian tribes of the United States. This legislation has the potential to not only correct deficiencies in the funding of Indian Health Service programs, but also would improve the overall delivery of health care services to American Indians and Alaskan Natives. Of particular importance to the Lac Courte Oreilles Tribe is the reauthorization of several separate titles. First of all, Title I and Title V regarding Community Health Representatives and Urban Indian Health Care Programs are very important to members of our tribe who live both on the reservation and in urban areas. We strongly support these titles. Also, we feel that the Indian Health Service should be elevated to a full agency of Public Health Service and strongly support this portion of the legislation.

Section 201 of the Indian Health Care Amendments pursuant to distribution of funds is another important facet of the legislation. We feel our programs have always been and continue to be underfunded pursuant to the needs of our members. Section 202 of the original legislation (that was vetoed by the President) addressed the issue of catastrophic coverage. We feel this program is of great importance to the members of the Lac Courte Oreilles Tribe. Our Contract Health Program has often been on priorities the past three years due to catastrophic illnesses. We strongly support this portion of the Senate Bill.

In closing, I would like to add that I feel that passage of the reauthorization of the Indian Health Care Act of 1976 is quite possibly the most far reaching and important piece of Indian health legislation in this decade. We strongly support your efforts and the efforts of the United States Senate to pass this much needed legislation.

Sincerely,

Dr. Rick St. Germaine
Tribal Chairman
Lac Courte Oreilles
Tribal Governing Board

WEBSTER TWO HAWK
President

BEN BLACK BEAR, JR.
Vice-President

Rosebud Sioux Tribe
ROSEBUD INDIAN RESERVATION
ROSEBUD, SOUTH DAKOTA 57570
Incorporated Under Act of June 18, 1934, 48 Stat - 984
PHONE: 605-747-2381

LLOYD B. ONE STAR, SR.
Secretary

CHARLES WHITE PIPE, JR.
Treasurer

1985 APR 22 AM 10: 46

April 16, 1985

The Honorable Mark Andrews
Chairman
Senate Select Committee on Indian Affairs
Washington, D. C. 20510

Dear Senator Andrews:

The Rosebud Sioux Tribe is pleased to have the opportunity to submit comments on S. 277, the bill to reauthorize the Indian Health Care Improvement Act of 1976. This bill-whether it is passed or vetoed-will have a profound affect on our Reservation. We, of course, hope for its passage.

I will comment on the parts of the bill which most directly affects us here on the Rosebud Sioux Reservation.

Once again, we express strong support for the continued funding of the Community Health Representatives Program, and hope that the question of its authorization under the Snyder Act is settled satisfactorily. In a reservation environment, with such factors as poor economy, distances, and inadequate funding of our local IHS hospital, the Community Health Representatives (CHR's) provide a vital link between primary health care providers and patients by providing home health information and education, and preventative health practices. And, more importantly, the CHR's are patient advocates and are providing an invaluable service by helping to eliminate the hesitancy (and fear) on the part of many of our Indian people to use hospital and primary health care services and personnel. Elimination or curtailment of the CHR Program would adversely affect our health care delivery system here on the Rosebud.

We feel that the inclusion of the Indian Catastrophic Health Emergency Fund is necessary, not only because it will help to meet the cost of unforeseen or extraordinary medical costs for victims of disasters or catastrophic illness, but also because the Contract Health Care funds allocated to local IHS hospital are almost always overexpended.

We support the provision of Title IV of S. 277, although we would like to see more of the Medicare and Medicaid funds returned to the service unit responsible for the collection. We also support the demonstration programs which would enable Tribes to bill directly and collect for Medicare and Medicaid for hospitals which are contracted under Public Law 93-638. The Rosebud Sioux Tribe plans to contract for the entire operation of the Rosebud IHS Service Unit.

The new provision under Title VII regarding the identification and coordination of resources to combat juvenile alcohol and drug abuse is especially important to us. Alcoholism is the number one disease on our Reservation and it is vitally important to alter the factors which leads young people to alcohol abuse. It is necessary to state here that we feel that the Indian Health Service must increase its committment to and support of programs which work to provide treatment and prevention of alcohol and drug abuse.

We reiterate our hope that S. 277 will not meet the same fate as S. 2166 did during the last session of the 98th Congress, and we appreciate your committee's fine efforts on behalf of Indian Health Care.

Sincerely,

Health Administrator

for Webster Two Hawk, Sr.
President
Rosebud Sioux Tribe

WTH/ae

1985 MAY -9 PM 4:51

ROGER HEDGECOCK
MAYOR

May 3, 1985

Senator Mark Andrews
Chairman, Senate Select Committee on
Indian Affairs
U.S. Senate
Washington, D.C. 20510

Dear Senator Andrews:

This letter is to express my strong support for the reauthorization of the Indian Health Care Improvement Act, and particularly Title V of this Act, Health Care for Urban Indians.

As you know, California has the single largest American Indian population in the United States, and the majority of this population live in urban areas.

The San Diego American Indian Health Center, funded through the Federal Indian Health Service, is the primary provider of health and human services to San Diego's urban Indian population. This center makes an extremely valuable contribution to the health of our city's residents.

On behalf of all the residents of San Diego, I urge your favorable consideration of this legislation. Thank you for your attention to this matter.

Sincerely,

Roger Hedgecock

ROGER HEDGECOCK

RH:esy

CONFEDERATED
TRIBES OF
SILETZ INDIANS
OF OREGON

P.O. BOX 549
SILETZ, OR 97380
GOVERNMENT HILL
PHONE (503) 444-2532

1985 APR 19 PM 1:55

April 15, 1985

Senator Mark Andrews
Chairman, Select Committee
on Indian Affairs
1208 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Andrews:

Please find enclosed testimony submitted on behalf of the Confederated Tribes of Siletz in support of S. 277 - Reauthorization of the Indian Health Care Improvement Act of 1976. Your support for this bill would be greatly appreciated.

Respectfully,

Arthur S. Bensell
Tribal Council Vice-Chairman

cc: Dr. Everett Rhoades
Northwest Portland Area
Indian Health Board

ASB:jlj

Testimony of the
Confederated Tribes of Siletz in support of
S.277 - Reauthorization of the
Indian Health Care Improvement Act of 1976

The Confederated Tribes of Siletz Indians of Oregon submits this testimony in support of S. 277, a bill to reauthorize the Indian Health Care Improvement Act of 1976. The Siletz Tribe was restored to federal recognition in 1977, following twenty-five years of termination. During that time tribal members were ineligible for Indian health services. A primary goal of restoration was to improve the general health of Siletz peoples, which had declined well below the national norm. The bill now before Congress authorizes and supports several IHS programs which the Siletz Tribe believes are important to the continued improvement of health care services available to the Siletz people.

The Siletz Tribe first wants to express its complete agreement with the testimony submitted by the Northwest Portland Area Indian Health Board in support of the legislation. The Board has represented tribes of the Northwest admirably for many years and its position on legislation such as S. 277 can be viewed as expressing accurately the position of the tribes it represents. To emphasize the importance of certain provisions of the bill, however, the Siletz Tribe submits the following.

Foremost amoung these provisions is the the Community Health Representative Program. Daily, it provides direct benefits to Siletz members through both preventive and direct services. One of these services is transportation. A substantial number of tribal members live in or near the city of Siletz, which is located approximately 100 miles from the nearest IHS Service Unit in Salem, Oregon. This 200 mile round trip is impossible for many tribal members, who are either without reliable transportation, without money for fuel, lunch and other requirements of an all day trip or are too elderly to travel alone. Community Health Representatives provide transportation when no alternative is available. This service has proven to be cost effective. Individuals who otherwise would not be seen by medical personnel seek preventive health care when they have access to medical facilities. And, everyone will agree that preventive medicine is much less expensive than care for chronic illness.

Tribal Community Health Representatives provide other types of direct health care assistance to tribal members. Such services include home visits to tribal elders to assist with bathing, nail trimming, dressing changes, and delivery of prescription drugs. Many of us take for granted the ability to perform these tasks but the elderly and disabled find them burdensome or impossible without assistance.

CHR's also regularly visit tribal families with infants. Special training in screening techniques enables them to identify developmental problems and insure that parents seek appropriate medical treatment. CHR's also provide blood pressure screenings on a regular basis. High blood pressure is a chronic condition amoung many tribal members. Regular monitoring by CHR's saves the cost of visits to the IHS clinic or the office of a contract care provider. It also increases the frequency of blood pressure checks.

Since restoration CHR's also have provided many hours of health education to tribal members. Topics have included nutrition, weight control, excercise, smoking and alcohol abuse. The benefits of this education is difficult to measure in dollars and cents, particularly since they may not clearly be evident until much later. Nonetheless, without question, the Community Health Representative Program for the Siletz Tribe has and continues to provide worthwhile, relatively inexpensive health care services to members - services that simply could not be replaced if the program were eliminated.

The Tribe has no objection to the bill's reference to the CHR Program being authorized by the Snyder Act. It is concerned, however, that the bill does not establish a specific appropriation for the program. The Tribe firmly believes that the program is important enough to warrant the inclusion of such a provision.

The Tribe also believes that the training requirements for CHR Program established by Section 108(b) should mandate that training be structured to include training regarding health concerns identified in tribal specific health plans. This could be done simply by adding the words, "and consistant with the needs identified in the tribal specific health plans of those tribes" to the end of Section 108(b)(6).

The Tribe also wants to emphasize its support for the continuation of tribal specific health planning in general. This policy is in keeping with the best aspects of Indian self-determination. The Tribe is convinced, however, that the Indian Health Service must be directed to take into account the plans of each individual tribe in determining the distribution of equity funds.

The Siletz Tribe also supports the continuation of the Indian Health Professions Preparatory Scholarship Program. Twenty-five percent of the Tribe's population is under the age of eighteen. Members have been eligible for education assistance from the BIA and IHS for only the last seven years. In the future this program can be utilized by our tribal members who seek careers in the medical field. Currently one tribal member attends a nursing program made possible through a scholarship from IHS. The Tribe believes the number of members participating in this program will increase considerably in the next few years. The Tribe also believes that tribal health will improve as more and more Indian health professionals are trained and employed by the Indian Health

Service. We are convinced that a greater sense of commitment exists when individuals serve their own people. Thus, the Tribe wants this program to continue.

The Tribe also supports the establishment of a catastropic Health Emergency Fund. No IHS hospitals exist in the Northwest. Thus, contract care funds are required for all hospital care. These funds are always insufficient to meet the needs. Even a single catastrophic illness can create a major shortfall in contract care funding. This results in greatly reduced levels of health services available. A catastrophic Health Emergency Fund will insure that individual Indians, afflicted with serious illness or disability, will receive the medical care they need. It also will insure that less severly ill Indians will not have their care jeopardized by a lack of funds.

SMALL TRIBES ORGANIZATION of WESTERN WASHINGTON
P.O. Box 578/Sumner, Washington 98390-0578/(206) 593-2894

March 27, 1985

RE

Honorable Mark Andrews, Chairman
Senate Select Committee on Indian Affairs
U. S. Senate
Washington, D. C. 20510

Dear Senator Andrews:

The Small Tribes Organization of Western Washington (STOWW) is an inter-tribal consortium composed of 15 small tribes and bands of American Indians in Western Washington State and 2 tribes in Oregon. STOWW is pleased to have the opportunity to present written testimony in support of S.277, a bill to reauthorize the Indian Health Care Improvement Act of 1976.

Since many Indian health organizations, tribes and individuals more knowledgeable about the bill have presented written and oral testimony in support of the reauthorization, I will only make very general comments about each of the titles contained in S.277.

Title I - Indian Health Manpower

STOWW supports the continuation and reauthorization of Title I, as it is the only reliable source of providing young Indian professionals for future service in the health care field.

There is a great need to assist our Indian students in entering and completing studies in the health profession. There is a problem of recruiting and keeping doctors and nurses on reservations. Most of these doctors and nurses are non-Indian and have a difficult time adjusting to the isolation and way of life of Indian people.

A program that encourages and provides financial aid for young Indians to enter the health professions is vital for the future improvement of health services to Indian people. Hopefully, the trained Indian professionals will return to serve on their reservations or with other Indian tribes or organizations.

We support the continuation of the Community Health Representative (CHR) program as it is a vital link in the Indian health care delivery systems. If it were not for CHR's, essential health delivery systems would not be available for some tribal people. It is imperative for the CHR program to be continued.

Title II - Health Services

We support the inclusion of Title II, which extends authority for programs to eliminate existing backlogs in clinical care, preventitive health, dental health, emergency medical services, alcoholism treatment and rehabilitation and maintenance and repairs.

We support the addition of Section 204, health promotion and disease prevention services to eligible Indian patients through the Indian Health Service.

Of particular concern to most Indian tribes is the urgent need to deal with the problems of alcohol and drug abuse, particularly among young people. Prevention and treatment of alcohol and drug abuse ranks as one of the highest priorities of most tribes. Funding levels of most alcohol projects is inadequate.

Title III - Health Facilities

STOWW supports the use of funds appropriated under the authority of the Snyder Act for the expenses of planning, design, construction or renovation of health facilities that may be incurred by a tribe or tribes under Indian Self-Determination grants or contracts.

In order to achieve quality health care for tribal people, it is necessary that funding for health facility construction, expansion and sanitation is provided. Capital investments made in IHS ambulatory care facilities pay a far greater dividend in health status improvements than the much larger investment necessary for hospital construction.

The facilities and equipment currently being utilized are, in many cases, inadequate and outdated. Consideration should be given to the expansion of existing health care facilities due to the increased number of Indian patients receiving direct health care services.

Title IV - Access to Health Services

STOWW supports the Title IV authority for grants and contracts with tribes and tribal organizations for the purpose of identifying and enrolling eligible Indian people in the Federal Medicare and Medicaid programs. If services are being provided to

Medicare or Medicaid-eligible Indians, then IHS should be reimbursed in order to improve services to Indian patients.

We also support the Title IV provision calling for IHS to return at least fifty percent (50%) of any funds collected from Medicare and Medicaid sources to the service unit of IHS that is responsible for the collection of such funds.

Title V - Health Services for Urban Indians

We support reauthorization of Title V. The urban Indian population consists mainly of reservation Indians who have relocated to urban areas in order to improve their opportunities in education, employment and standards of living. These Indian people still have a pressing need for health care services.

Title VI - Organizational Improvements

We support the creation of the position of Assistant Secretary for Indian Health which will provide for increased IHS effectiveness and management; less review and reporting; and increased accountability to Congress and the Indian people.

Title VII - Miscellaneous

We support provisions of Title VII which

- authorize the Secretary of HHS to enter into legal agreements with tribes or tribal organizations for costs associated with the use of facilities owned by the tribe or organization and which are used for administration and delivery of health services by IHS.
- direct the Secretary of HHS to enter into an agreement with the Secretaries of the Interior and Education to coordinate the efforts of the departments related to alcohol and drug abuse among Indian juveniles.
- direct the Secretary to establish an Office of Alcohol and Drug Abuse within the IHS.

On behalf of our member tribes, we thank you and members of the Senate Select Committee on Indian Affairs for your concern in addressing the health needs of American Indian people.

Respectfully,

Patrick J. Clements

Patrick J. Clements
Executive Director

Prepared

Testimony of the Standing Rock Sioux Tribe on S. 277, a bill to reauthorize and amend The Indian Health Care Improvement Act.

On behalf of the Standing Rock Sioux Tribe, we would like to thank the Senate Select Committee on Indian Affairs for the opportunity to present our views on S.277, a bill to reauthorize and amend the Indian Health Care Improvement Act. Please include our testimony in the record of the hearing held before the Committee on March 6, 1985.

Last year, Congress passed S.2166, a bill similar to S.277. The Tribe strongly supported that bill, and greatly appreciated the fine work of this Committee in achieving its passage. That bill should be law today - but it was vetoed. Unless there is further Congressional action, this veto will place federal and tribal efforts to improve the health of Indian people in serious jeopardy. The Standing Rock Sioux Tribe calls on President Reagan and officials from the Department of Health and Human Services to work closely with this Committee and the relevant committees in the House to enact this bill. Even with passage of this bill the health needs of the Indian people will not be on a par with those of others in this country.

I would like to express the Tribe's particular support for several provisions of S.277, and also bring several serious health problems at Standing Rock to the Committee's attention.

Title I, Indian Health Manpower and the Community Health Representative Program.

The Tribe strongly supports the proposed reauthorization of the the Indian Health Manpower programs, which include both scholarship and recruitment programs. We are very concerned that the Administration is proposing to phase out these programs. In the Aberdeen area, IHS has experienced severe problems in recruiting Indian health professionals, particularly physicians, and in keeping those professionals once they are recruited. In the Fiscal Year 1985 profile of the Aberdeen area of IHS, area officials state that there is "a crisis in the recruitment and retention of physicians." Obviously, the Administration's proposal to eliminate funds for recruitment would deepen this crisis.

Funds for health scholarships are crucial as well. The recent articles in the Washington Post concerning the Rosebud Reservation, which were referred to by Senator Pressler at the Committee's March 6 hearing, described the shockingly high turnover of health professionals employed by IHS on the Rosebud Reservation. At Standing Rock, we have experienced the same problem. In fact, we have never had a physician work for IHS on our Reservation for more than 1½ years. However, Indian health professionals are much more likely to remain on the job for significant periods of time than are their non-Indian counterparts. Therefore, a larger pool of Indian health professionals would greatly contribute to the stability of the IHS workforce. If this is to be achieved, scholarship funds are needed because many Indian students need financial assistance in securing the necessary training. In particular, we request increased support for the INMED program which is a step in the direction of filling this unmet need.

The Tribe applauds this Committee's efforts to strengthen the Community Health Representatives (CHR) program, including placement of the program under authority of the Snyder Act and establishing standards for CHR programs. We are shocked that the Administration is again proposing to eliminate this program. We believe that this is perhaps the most important single health program on the Reservation. Rather than elimination, efforts should be focused on how to improve the program. For example, additional training of CHRs as health practitioners would be a major step forward. CHRs now provide the first line of medical care on the Reservation. They provide emergency services in the communities and provide a vital communications link between our people and the medical staff at the clinics. They are known and trusted by our traditional people, many of whom are wary of other health care personnel. Without CHRs, many of our people would literally never receive modern health care. Also, we believe that the CHR program ultimately saves money for IHS, because the CHRs insure that patients come into the clinics for treatment before their conditions become acute and therefore much more expensive to treat.

Title II, Health Services.

Title II would authorize funds for bringing the health status of all Indians to the "zero level" of deficiency. The Tribe supports all efforts to meet this important goal. Funds appropriated under this Title could be spent in a number of areas, including for emergency medical services. At Standing Rock, we have a particular need for funds in this area.

As the Committee is aware, the Standing Rock Reservation is quite large, and there are Indian communities scattered throughout the Reservation. However, there is only one inpatient facility on the Reservation, at Fort Yates, and in emergencies all patients must be brought to that facility. The problem is with emergency transportation. The CHRs frequently provide emergency transportion, but this takes large amounts of time away from their other duties, and even so, does not fill the need for transportation.

We are concerned that the situation will become even *worse because IHS officials acknowledged at a recent House* Appropriations hearing that under the Administration's proposed funding cuts for emergency medical services in FY 1986, the Indian people can expect even greater delays in response to emergency situations. This may mean further cuts in ambulance services. We are hopeful that enactment of S.277 will produce an infusion of funds to this vital area.

The Tribe also supports Section 204 of Title II, which would require IHS to provide health promotion and disease prevention services to Indians. One specific area of concern at Standing Rock is diabetes. There is a very high and increasing incidence of diabetes among the Indians of Standing Rock. The Aberdeen area recently listed diabetes prevention as a priority for FY 1985, but there is no program at Standing Rock. Both children and adults need to be taught the importance of weight control, diet, and other factors in reducing the severity of diabetes. We suggest that the definitions in Section 204(b) be amended to specifically mention diabetes.

Title III, Health and Sanitation Facilities

Funding for decent sanitation facilities has been a chronic problem at Standing Rock. In the early 1960s, the IHS began to construct domestic water and sanitation facilities on the Reservation under P.L. 86-121. Without consultation with the Tribe, IHS installed an inadequate system. Then, IHS demanded that the Tribe take over and run the system without so much as providing the Tribe with a blueprint to locate the pipelines.

For years, when problems arose in the system, IHS and BIA both told the Tribe to go elsewhere for funds. In other words, the federal government built these poor systems, and then dumped them on the Tribes without funds to keep them operating properly. The situation has now deteriorated to the point that our communities often suffer without water and sanitation facilities for days at a time, sometimes to the point of causing serious health threats.

Title III of S.277 would provide at least a partial solution to this problem. In addition to requiring IHS to prepare a ten year plan to provide safe water and sanitation facilities to new and existing Indian homes, it would authorize IHS to provide operation and maintenance assistance and emergency repairs to tribal sanitation facilities when necessary to avoid a health hazard or to protect the federal investment. This provision would apply in situations where the tribe cannot provide these services with its own resources. The bill authorizes $5 million for provision of these services.

This is an excellent provision, but we suggest that it be taken even further. The bill should be amended to make clear that in any situation where user fees cannot cover the cost of operation, maintenance, or repairs, IHS is responsible for the cost. Second, although we recognize that current fiscal restraints will make this difficult, we strongly suggest that the $5 million authorization be increased. Third, we suggest that when the Committee reports the bill, it include report language acknowledging that the IHS policy of turning over sanitation facilities to tribes without the resources to pay for them, combined with construction of poor facilities in the first place, has created a substantial burden for tribes, and directing that IHS use its resources to alleviate this problem.

Title V, Urban Indian Programs

We agree with the continuation of the Urban Indian Health programs under this section. Our enrolled members residing off-Reservation are in great need of health care. This section would provide these much-needed services to Indians off the Reservation rather than forcing these persons to return to the Reservation to receive this care. If there is no Urban Indian health program, there will be a major increased burden to local service units on the Reservation.

Title VI, Organizational improvements.

Title VI of S.277 would remove IHS from the jurisdiction of the Health Resources and Services Administration (HRSA) and make it an agency within the Public Health Service (PHS). We simply cannot understand why this provision, which involves no new expenditures and would almost certainly save money, has not been supported by the Administration.

IHS has been plagued with management problems which Title VI would do much to solve. This Title would give the IHS director a stronger voice in budget and policy matters and would remove several layers of bureaucracy and red tape from decisions affecting Indian health. Title VI would also give the IHS director responsibility for personnel and procurement matters, which would eliminate the ill-advised decisions and delays we have seen in these areas in the past. The Tribe applauds the effort of this Committee to bring about these much needed organizational improvements.

Title VII, Section 702, Juvenile Alcohol and Drug Abuse

Section 702 of S.277 would require the Secretary of HHS to take several important steps to combat drug and alcohol abuse. The Tribe supports this provision, particularly the portion of it that would provide students with classroom training in schools on or near Indian reservations. We recommend that Tribes be involved in implementing training on drug and alcohol abuse for our Indian students.

We would also like to point out a serious unmet need at Standing Rock that is related to drug and alcohol abuse. We used to have an inpatient treatment facility on the Reservation for those with severe alcohol problems, but it was closed in 1981 due to budget cuts. Now, alcoholics are often placed in jail temporarily or are sent off the Reservation often to state facilites where the programs are not designed to meet unique Indian needs. There are a few programs specifically designed for Indians, but they have very long waiting lists and therefore are useless to those with acute problems.

We realize that in a year when Congress is looking to cut the budget and any new spending programs are highly suspect, it will be difficult to obtain funds for more alcohol treatment facilities. Given these constraints, we support the approach taken by H.R. 1156, a House bill that deals with drug and alcohol abuse among Indian youth. That bill would require IHS to conduct a study to identify needed alcohol treatment facilities, and eventually to request Congress to fund the needed facilities. We suggest that a similar provision be included in S.277. In the alternative, we ask that the members of this Committee introduce a bill similar to H.R.1156.

Once again, we appreciate the opportunity to present our views to this Committee.

Respectfully submitted,

Charles Murphy
Chairman

Allen White Lightning
Tribal Councilmember

Standing Rock Sioux Tribe

United South and Eastern Tribes, Inc.
1101 Kermit Drive • Suite 800 • Nashville, TN 37217-2190
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Officers
Leonard Garrow, President
Joel Frank, Vice President
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Member Tribes
Cherokee
Chitimacha
Choctaw
Coushatta
Creek
Maliseet
Miccosukee
Mohawk
Narragansett
Passamaquoddy
Penobscot
Pequot
Seminole
Seneca
Tunica/Biloxi

March 19, 1985

RECEIVED APR 0 5 1985

Senator Mark Andrews, Chairman
Senate Select Committee on
Indian Affairs
640 Dirksen Senate Office Bldg.
Washington, D.C. 20510

Dear Senator Andrews:

The membership of the United South and Eastern Tribes includes sixteen federally recognized American Indian Tribes in what is traditionally known as the USET area. The member Tribes for many years have recognized the need for proper health services in order to further the self-determination of their people. In 1972, as part of its commitment to the policy of self-determination, the federal government through the Indian Health Service established the U.S.E.T. Program Office. The office for the first time in history provided resources to the eastern Tribes separate from the Oklahoma Tribes, thereby giving the eastern Tribes a chance to be consulted in the operation and allocation of health resources to the Indian people in the east. Since that time, the improvement in health care provided the Indian people in the east has mirrored the accomplishments of Tribal health care nationwide.

The U.S.E.T. Tribes are in support of continued provisions of health resources for the Indian people in this great nation. Therefore, we encourage the reauthorization of the Indian Health Care Improvement Act in order that the national policy of raising the health status of Indians to a zero level of deficiency as defined therein in the Act:

> By eliminating backlogs in health care services and meeting unmet health needs as soon as possible and in an equitable manner.

"Because there is strength in Unity"

The need for adequate health services is critical and needs to be addressed expeditiously. We ask that the Committee be cognizant of the differences between the health care provided in the east and elsewhere in Indian Country. The philosophy that set up the eastern services was one that held that Indian Tribes have the necessary abilities to best provide health services to their people. With that in mind, and taking into account that since the inception of the USET Program Office (changed in 1982 to the Nashville Program Office) that the number of eligible Tribes has risen from five to eighteen; that the service population has risen over 60%; and that over 65% of the area budget is contracted to the Tribes, you can see that the needs and problems of the eastern Tribes are significantly different from the other Tribes.

In closing, we urge the Committee to support the reauthorization of the Indian Health Care Improvement Act. Thanking you for your time and cooperation, I remain-

Sincerely,

Leonard V Garrow
Leonard V. Garrow
President

tds

#01318

April 1, 1985

To Whom It May Concern:

Thank you for the opportunity to present the views of the United South and Eastern Tribes, Inc. concerning Senate Bill 277 which amends and reauthorizes the Indian Health Care Improvement Act.

Title I of the Bill is a particularly important section to us since it deals with Indian Health Manpower. Most of the health care delivered to Indians in the USET area is done so through tribal contracts. Accordingly, we are very supportive of any measures that can be taken to encourage and facilitate entry of Indians in the health professions. Although the tribal programs are currently managed and staffed predominantly by Indians, there exists a distinct shortage of Indians in higher level health provider roles. The provisions of Title I would assist in overcoming this shortage and thereby better adapt the programs to the needs of the tribal communities being served.

In addition, Title I addresses the need for continuance and strengthening of the Community Health Representative program. This element constitutes the interface between the health program and the Indian people and is critically needed. Primarily a prevention oriented program, the CHR program represents hope that in the future Indians can overcome elevated mortality and moridity through healthier lifestyles, improved chronic disease management and disease/injury avoidance. The CHR program will be the leading edge of this endeavor.

It is encouraging to see in Title II of the Bill that the Senate recognizes the resource requirements to bring all Indian Health Care programs to full funding levels. Particularly since the IHS and tribal programs face huge backlogs of health care problems it is clear that a systematic reduction of unmet need is fundamental to eventual success in meeting the challenges posed by the deteriorated health status in Indian people.

Title II also incorporates the Catastrophic Health Emergency Fund that has been a demonstrated need of IHS for some time. The availability of these resources to accommodate unusual instance of cost to the program will help to provide for much more systematic budget and program management.

The provisions of Title II that relate to health promotion and disease prevention are very important to the future of Indian Health Care. As is typically the case, the bulk of IHS resources (inadequate as they are) are expended on treatment, often late stage. A systematic approach to program reorientation toward health promotion and disease prevention will ultimately bring the greatest payoff to Indian people.

Health facilities which are addressed by Title III of the Bill are especially important to the USET area tribes since many are in start-up phases of development. In this regard, Title VII provisions which specifically allow tribes to lease health facilities to the IHS for tribal program use are of critical importance. The emphasis on sanitation facilities is also of major importance since many tribes are beginning to find that many health programs are directly and indirectly traceable to the contamination of water supplies and other environmental hazards.

The increased flexibility of Medicare and Medicaid collections is very beneficial to tribally operated programs. In the USET area, only one site is a direct IHS program and most care is provided in tribally contracted outpatient clinics. It is, therefore, very important that providers outside the IHS and various types of facilities be allowed access to Medicare and Medicaid resources.

The USET area supports Title V of the Bill which addresses the need for Health Services for Urban Indians. It is well known that Indians that are forced to leave their reservations out of economic necessity are in need of culturally sensitive health care services.

In Title VI of the Bill addresses the management information needs of the IHS which are also a concern of tribal programs. Tribal programs are forced to participate in the ineffective data systems of IHS and end up expending major effort with practically no payback in terms of management information. Likewise, the agency itself is compromised by the absence of accurate, responsive data systems.

Title VI also deals with the organizational positioning of IHS within the Department of Health and Human Services. The sometimes less than supportive relationship that IHS has with the Health Resources and Service Administration is a well known deterrent to effective and responsive health care delivery. Evaluation on the IHS to an agency level will automatically dispose of a majority of the bureaucrataic problems it has been experiencing and will also convey recognition of the importance of IHS in the overall scheme.

The United South and Eastern Tribes, Inc. wishes to express its strong support for Senate Bill 277 which is critical to the progress of Indian Health Care. The health needs of Indian people have been under-recognized for too long and this Bill represents a good attempt to correct this situation.

COUNTY OF VALLEY
Department of Public Welfare
Box 272
GLASGOW, MONTANA 59230

Economic Assistance
Phone: 228-2489

Social Services
Phone: 228-8281

March 14, 1985

Senator John Melcher
730 Hart Senate Office Building
Washington, D.C. 20510

Re: Indian Health Services

Dear Senator Melcher:

Carole Graham, President of the Montana County Director's Association, said that you had requested information as to the first instance where Indian Health Services refused to pay. Following is that information.

Valley County - Fort Peck Reservation

Our first denial came in June, 1982 when the IHS refused to pay for hospitalization for the unenrolled child of an enrolled member. We refused to pay and they later paid this.

Phillips County - Fort Belknap Reservation

Our first one in Phillips County was in September, 1982. An IHS physician had seen and referred a white spouse to Havre for surgery. We were contacted after the surgery. IHS refused to pay. This case is now in Montana District Court.

Since that time we have had applications from enrolled members residing on both reservations.

If you have questions or comments please contact me.

Sincerely,

(Mrs) Delores M. Shelton, County Director III
for Phillips and Valley Counties

DMS/ga

cc: Max Richtmen, Minority Staff Director

Prepared
Testimony of the Washoe Tribal Council
S. 277 - "The Indian Health Care Amendments of 1985"

The Washoe Tribe of Nevada and California strongly urges the members of the Nevada Congressional delegation to support passage of S. 277, the "Indian Health Care Amendments of 1985." During the past five years, the Washoe Tribe has successfully used the resources and authorities of the Indian Health Care Improvement Act to plan and operate a full service outpatient clinic.

Washoe Tribe Health Clinic

The Washoe Tribe health clinic offers a full range of outpatient services to tribal members and other Indians living in Nevada and California. These services include:

- Preventive Health Care
- General Medicine
- Dental Services
- Optometry/Ophthamology
- Nutrition Counseling
- Mental Health
- Pharmacy
- Home Health Care
- Laboratory Services
- Health Records

The service population includes 2300 Washoe and other Indian people living in Western Nevada and another 900 tribal members who live in California, including the Bay Area, who frequently use the clinic.

Staffing for the clinic includes:

Clinic Director -	IHS employee detailed to the Washoe Tribe through a Memorandum of Agreement (MOA) between IHS and the Washoe Tribe.
Physician -	IHS employee detailed to Washoe full-time through MOA.
Optometrist -	IHS employee detailed to Washoe two days per week.
Psychologist -	IHS employee detailed to Washoe one day per week.
Nutritionist -	ITCN consultant detailed to Washoe two days per month.
Registered Nurse -	Washoe Tribe employee, 3/4 time.
Licensed Practical Nurse -	Washoe Tribe employee, full-time.

Dentist -	IHS employee detailed to Washoe Tribe full-time through MOA.
Dental Assistant -	Washoe Tribe employee, full-time.
Medical Record Technician	Washoe Tribe employee, full-time.
Receptionist Clerk/Typist-	Washoe Tribe employee, full-time.
Housekeeper/Courier -	Washoe Tribe employee, full-time.
Community Health Nurse -	IHS employee assigned full-time to Washoe Clinic service area.
Patient Transportation Driver	Washoe Tribe employee, full-time.

It is apparent from this list of staff that the Washoe Tribe Health Clinic is supported by a variety of resources: a Clinical Services PL 93-638 contract with IHS, Equity Health Care Fund dollars, and IHS staff assigned to Washoe Clinic through Memoranda of Agreement. These additional resources are available because of the Indian Health Care Improvement Act. Without the Act, IHS would not have been able to detail staff to tribal clinics. Without the Act, additional funds for tribal contracts would not exist.

Health Care Progress

Prior to the opening of the Washoe Clinic, tribal .members had to travel to Schurz Indian Hospital on the Walker River Reservation for basic outpatient health care. This is a 180 mile round-trip. In the winter, these distances were more difficult because of snow and icy roads. These geographical conditions made pre-natal, well-child and other preventive services difficult to obtain. People often postponed clinic visits until emergencies developed, causing problems for the patient, difficulties for hospital staff, and increased use of Contract Health Service dollars.

In the five years since the Washoe Tribe Health Clinic opened, there has been greater utilization of available preventive care services. Women use the clinic for initial pre-natal visits, then are referred to local obstetricians for ongoing care and deliveries. Children are brought in for immunizations and well-child care. Diabetics are closely monitored, preventing complications such as renal failure, heart disease, blindness, amputations or death. Dental care is accessible, which prevents major oral diseases.

The greater access to services, and the greater use of preventive health services, has reduced the rates of hospitalization and unnecessary emergency room visits. This,. in turn, has eased the burden on the Contract Health Services budget in the Schurz Service Unit. This is important since Indian tribes in Nevada are particularly dependent upon Contract Health Services for inpatient care and for specialty outpatient services.

Importance of Enacting the Bill

Fortunately, health services to Indian people were unaffected by the veto of S. 2166 because of a ruling that the Continuing Appropriations Resolution contained the authority to continue programs authorized by the Indian Health Care Improvement Act for one year. However, we are concerned that failure to enact authorizing legislation in this fiscal year will jeoparize future operation of the Washoe Tribe Health Clinic.

WASHOE TRIBE COMMENTS ON S.277

The following comments reflect recommendations for improvements to specific sections of the bill.

TITLE I - INDIAN HEALTH MANPOWER

We support the reauthorization of Indian Health scholarships and recruitment programs.

TITLE II - HEALTH SERVICES

The Washoe Tribe supports the establishment of the Indian Health Care Improvement Fund. We especially support the needs-based approach to defining budget levels. This provision would provide a mechanism to enable the Congress to receive more objective information from the Indian Health Service regarding the amounts of funding needed to address Indian health deficiencies.

We recommend that Section 201(b)(2) be changed to read:

"(2) Where any funds allocated under this title to a tribe or service unit are used for a contract under the Indian Self-Determination and Education Assistance Act, not more than 15 percent of such funds shall be used for health planning or training."

We are concerned that "other administrative support functions" could be interpreted to mean indirect costs.

We support the establishment of the Catastophic Health Emergency Fund.

We support waiver of Competitive Procurement requirements when medically necessary.

We support the Health Promotion and Disease Prevention language. These are a major emphasis of the Washoe Tribe Health Clinic.

TITLE III - HEALTH FACILITIES

We support the reauthorization of facilities construction. We also support the provision for tribal governments to contract under PL 93-638 for facilities construction.

Safe Water and Sanitary Waste Disposal Facilities are a major priority for the Washoe Tribe. It is very clear that the construction, and maintenance and operation, of safe drinking water and sanitary waste disposal systems on Indian reservations has had a major impact on reducing the incidence of gastroenteritis, diahrrea and infant mortality. There is no doubt that these systems are a health concern.

We support the needs-based approach to identifying funding levels for safe water and sanitary waste disposal facilities. There are still major unmet needs for these facilities in at least 14 Indian communities in Western Nevada.

TITLE IV - ACCESS TO HEALTH SERVICES

We strongly support Grants and Contracts with Tribal Organizations. This is a very important provision, and should be implemented. This provision was contained in the 1980 amendments, but funding was never provided to implement these grants.

Medicare, Medicaid and private insurance collections will never be maximized until tribal governments adopt policies requiring tribal members to use their benefits, and provide assistance with enrollment and paperwork.

During the past four years, the Indian Health Service in the Phoenix Area has used an adversary approach against Indian patients, forcing them to apply for third party resources under the threat of losing eligibility for Contract Health Services. But IHS has failed to provide explanations to Indian patients regarding the necessity of using third party benefits.

A new approach is needed. It is time for IHS to begin working cooperatively with tribal governments, to share information about third party policies, instead of dealing unilaterally with states. It is time to begin using an educational approach with Indian patients, instead of an adversary approach.

Medicare provisions: The provision to allow service units to keep 50% of their own collections is a step in the right direction. However, much more is needed.

There are disincentives for service units to make an effort to collect third party resources. These funds are placed into a "special fund," supposedly to be used to upgrade deficient facilities. However, there is never any accounting back to service units or tribal governments on the use of these funds. There are suspicions that these funds are held as carry-over and used for administrative "slush funds," and to meet the annual Pay Act crisis.

We recommend that Congress direct IHS to accurately account for Medicare and Medicaid collections, and the use of those revenues, by service unit and by Area.

Medicaid provisions: Clarification is needed on the proposed Section 403(c) which reads:

"The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Service facilities to Indians who are eligible for medical assistance under the State plan."

This provision does not make sense.

We support the Demonstration Program for Direct Billing of Medicare, Medicaid and Other Third Party Payors. The Washoe Tribe would like to consider becoming one of the demonstration projects.

We recommend that this study be supervised by the Health Care Finance Administration, Office of Research and Demonstrations. HCFA has expertise in health financing, and would be more objective than IHS.

We also recommend that the Study of Barriers to Participation be carried out by the Health Care Finance Administration. This study should not be carried out by IHS because IHS is the barrier. Specific barrier problems include:

- IHS's adversarial approach to forcing Indian patients to apply for third party resources,
- lack of cost-based financial management systems at the service units, which prevents IHS from billing private insurers using cost-accounted bills,
- lack of coordination between IHS direct services dollars, Contract Health Service dollars, and third party revenues,
- lack of communication between IHS and tribes regarding available resources,
- lack of controls on the expenditures of Contract Health Service dollars,
- waiting until Contract Health Service dollars have run low, then forcing Indian patients to apply for third-party resources in a crisis mode.

TITLE V - HEALTH SERVICES FOR URBAN INDIANS

The Washoe Tribe supports reauthorization of Title V programs. Many Washoe tribal members live and work in urban areas such as Reno, Los Angeles and the Bay Area. We believe that these tribal members should have access to quality health services.

We disagree with the rationale given by the Administration for the elimination of funding for these programs. Urban Indian health programs usually do not qualify for health block grants because the legislation ties funding to programs previously funded under categorical grants.

TITLE VI - ORGANIZATIONAL IMPROVEMENTS

We believe that development of a Management Information System which includes a cost accounting system is a much-needed step in the right direction. However, we urge Congress to specify that the cost-accounting systems should be at the level of the service units, not at the Area Offices.

Developing Management Information Systems, and cost accounting systems for Area Offices will not meet any of the information needs of service units, tribes or Congress. This would, instead, increase the burden of responding to Area Office demands for reports.

Currently we send in Ambulatory Patient Care (APC) reports from our clinic providers for IHS's computerized information system. Getting reports back from that system is nearly impossible. And when we do get the APC print-outs, they are inaccurate and unintelligible. The APC system is not user-oriented. It is merely a justification for the Data Processing Services Center (DPSC) at Albuquerque "Headquarters West."

Congress should be very specific about mandating these systems for improving service units and tribal facilities, and should prohibit any further expenditures of funds for national, monolithic, unusable computer systems developed by "Headquarters West" or the "Office of Research and Development." We do not want to see a repeat of the approach taken by the Bureau of Indian Affairs: buy $20 million worth of computer hardware, then figure out later what to do with it. These problems, which have been documented by numerous GAO reports, and by tribal testimony, continue to grow worse every year.

IHS Placed Within Public Health Service: It is difficult to address the proposed elevation of the Indian Health Service. According to the "History of the IHS 1985 Request," and the 1986 Budget Request, the Health Services and Resources Administration (HRSA) has supported the IHS requests for increased appropriations. It appears from those documents that the real opposition to adequate levels of funding for Indian Health has come from the Public Health Service, the Office of the Secretary, and the Office of Management and Budget. However, if this proposed organizational change will enable Congress to gain better access to objective information regarding Indian health needs, then perhaps it will be beneficial.

TITLE VII - MISCELLANEOUS

We support the provisions for Leasing. We also support the Juvenile Alcohol and Drug Abuse provisions.

Nevada is a nuclear waste dump site state. These nuclear wastes have serious health implications for native communities in Nevada. Therefore, we support the Nuclear Resource Development Health Hazards study.

We strongly agree with, and support the provision to prevent IHS from arbitrarily removing National Health Service Corps personnel from IHS or tribal facilities. We recommend that this provision be extended to include IHS personnel assigned to tribal clinics through Memoranda of Agreement (MOA).

Recently, the Phoenix Area Office Chief Dental Officer attempted to remove the dentist from the Washoe Clinic, without communicating with the Tribal Chairman or the Clinic Director. This was an arbitrary action, based on unsubstantiated charges. The Chief Dental Officer made no provisions for maintaining the ongoing level of dental services.

It took a great deal of the Tribal Chairman's time and effort, including meetings with Area Office personnel, to resolve this situation. According to the MOA between the Washoe Tribe and the IHS, the Tribal Chairman is the line supervisor for the clinic staff, not the Chief Dental Officer. We strongly believe that this sort of arbitrary misuse of authority should not be allowed.

Service to Ineligible Persons: We support this provision as written. However, we remind the members of Congress that IHS has no way of identifying the "actual cost of services," since service units do not have cost-based financial management systems.

WASHOE TRIBE OF NEVADA AND CALIFORNIA
20 MARCH 1985

March 1, 1985

RECEIVED [illegible]

Senator Mark Andrews
Chairman Senate Select Committee
on Indian Affairs
United States Senate
Washington D.C. 90510

Dear Senator Andrews,

Enclosed in this envelope are signatures of American Indians of California who support the reauthorization of P.L. 94-437 Title I Scholarships for American Indian students presently in health professional schools or preparing for admission to health professional schools.

These signatures were gathered at the Orange County Indian Center monthly pow-wow. All who were in attendance at the pow-wow were greatly concerned in regards to the changes being made by the United States government. We feel that our Indian students entering into the health profession would be reduced even further if federal aid was to be discontinued. Reservations and urban Indian communities are in great need of medical care and at this point in time the younger generation, including myself, are trying to do something about the lack of health care for our Indian people.

In order to overcome these health professional shortages, federal aid must continue. Many of our Indian students are at the stage in their medical careers where their professional degrees or undergraduste degrees are an arm's length away. Please don't lengthen this distance by discontinuing federal aid to our American Indian students.

Sincerely Yours,

Laura A. Williams

Laura Ann Williams
IHS Scholarship Recipient
California Juaneno Princess

Enclosures

[Editor's note:

Attachments consist of five petitions, a total of 96 names, and are now retained in the files of the committee.]

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